

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Behavioral Health Advisory Committee (BHAC)

Number of Members: 19

Committee Status (Ongoing or Inactive): Ongoing Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1/15/2016 **Date to Be Abolished:** 7/1/2020

Budget Strategy (Strategies) (e.g. 1-2-4)	Strategy Title (e.g. Occupational Licensing)
2-2-1	Mental Health Svcs - Adults DSHS
2-2-2	Mental Health Services - Crisis DSHS
2-2-3	Mental Health Services - Crisis DSHS
2-2-5	Substance Abuse Prevention, Intervention and Treatment DSHS
1-1-11	Enterprise Oversight HHSC staff support the BHAC

State / Federal Authority
 State Authority

Select Type

Identify Specific Citation

Statute	Government Code 531, Sec. 531.012; HSC §532.020; 84th Leg, SB277 & SB200
	42 USC §300x-3 & §300x-4

State Authority

State Authority
 Federal Authority
 Federal Authority
 Federal Authority

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel		\$21,978	\$21,978
Personnel		\$5,563	\$5,563
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$27,541	\$27,541

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$27,541	\$27,541

Meetings Per Fiscal Year

0	4	4	OMHC BHAC Information 05/04/16z
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Committee Description:

The Behavioral Health Advisory Committee (BHAC) was reconstituted from The Council for Advising and Planning (CAP) for the Prevention and Treatment of Mental and Substance Use Disorders, per management action based on the Sunset report. The CAP will be a subcommittee of the Behavioral Health Advisory Committee under HHSC to meet requirements for a mental health planning council under federal law. (84th Leg, SB 277 & SB 200). The BHAC also absorbed the System of Care Consortium and the Texas Children Recovering from Trauma which will be subcommittee under BHAC. Note: Expenditures for support of the Council on Advising and Planning and the creation of the BHAC totaled \$27,541 in 2015, with \$21,978 for travel and \$5,563 for personnel.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. The committee is new and does not yet have bylaws.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? (DSHS and HHSC staff combined for a total of 250 hours on CAP and the establishment of the BHAC)

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

- youth/young adult consumer of mental health and/or substance abuse services
- family representatives of consumers of mental health and/or substance abuse services
- adult peer provider
- representative of the Texas Council of Community Centers
- representative of the Association of Substance Abuse Programs
- independent community behavioral health service providers
- behavioral health advocates or representatives of behavioral health advocacy organizations
- representative of the Interagency Coordinating Group for faith and community-based organizations
- representative of a managed care organization
- representatives of local government, representing both urban and rural counties
- Additional members who have demonstrated an interest in and knowledge of the issues and services related to behavioral health

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Removing the committee would leave the HHS system with no stakeholder forum for input on behavioral health issues.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Not yet; too soon to determine

**Behavioral Health Advisory Committee
Meeting #1 Meeting Minutes
Friday, January 15, 2016
9:00 a.m. to 3:00 p.m.**

**Health and Human Services Commission
Brown-Heatly Building
Public Hearing Rooms 1420 and 1430
4900 North Lamar Blvd
Austin, TX 78751**

Agenda Item 1: Welcome

The Behavioral Health Advisory Committee (BHAC) meeting commenced at 9:00 a.m. with Sonja Gaines, Associate Commissioner of Mental Health, Health and Human Services Commission (HHSC) presiding as chair. Ms. Gaines welcomed everyone to the meeting.

Agenda Item 2: Welcome and opening remarks

HHSC Executive Commissioner Chris Traylor provided a brief overview of the impact mental health has on the programs and services across the Health and Human Services (HHS) system.

Ms. Cassandra Marx, Facilitator, announced that the meeting was being conducted in accordance with the Texas Open Meetings Act. Ms. Marx noted that a quorum was present for the meeting. Table 1 notes committee member attendance.

Table 1: The Behavioral Health Advisory Committee member attendance at the Friday, January 15, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Afejuku, Ayo MD	X		Johnson, Windy		X
Aylor, Candace	X		Kliwer, John MD	X	
Barrones-Soto, Jr. Leroy	X		Leon, Carlos	X	
Castaneda, Elizabeth	X		Osadchey, Lidya	X	
Feehery, Matthew	X		Richardson, Andrea	X	
Horton, Colleen	X		Scott, Nakia MD	X	
Howell, Jason	X		Wolff, Matthew	X	
Humphrey, Cynthia	X		Young, Wayne	X	
Johnson, Celeste	X		Zaragoza, Evelyn	X	

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 3: Charge and roles committee overview, structure, and deliverables

Ms. Gaines noted that her office, in conjunction with the Department of State Health Services (DSHS), will be coordinating the BHAC jointly.

Highlights of the discussion included:

- Senate Bill 200 and Senate Bill 277, 84th Legislature, Regular Session, 2015, required the HHSC Executive Commissioner to establish and maintain advisory committees to consider issues and solicit public input across major areas of the HHS system, including behavioral health. HHSC was directed to establish a behavioral health advisory committee to provide regular input and make recommendations

regarding mental health and substance abuse programs across the health and human services system.

- Ms. Gaines announced that Mr. Wayne Young, Vice President of Behavioral Health Services at John Peter Smith Hospital in Tarrant County, has graciously accepted the interim chair position until a chair has been elected by the Committee.
- The purpose of BHAC is to consider issues and solicit public input across all mental health and substance abuse disorder issues.

Action Item:

- Ms. Vicki Magee will provide members with an updated handout of the diagram showing the behavioral health committees.

Agenda Item 4: Introduction of committee members

Members introduced themselves and provided background information on their experience and expertise.

Agenda Item 5: Logistics for future meetings, officer elections, subcommittee structures

Ms. Carissa Dougherty, DSHS, and Ms. Magee will be the state staff supporting the Committee.

The BHAC has two standing subcommittees. The first subcommittee was a main function of the previous Council for Advising and Planning (CAP) and will be called the Block Grant subcommittee. In order to meet federal requirements for Mental Health Block Grant funds, the criteria for this subcommittee is being met by membership in this room, the Block Grant subcommittee membership which includes nine state agency representatives and volunteers from the previous CAP.

The other standing subcommittee is a consolidation of the Texas System of Care Consortium and the Texas Children Recovering from Trauma Initiative and membership of those two federal grants will be combined to inform program policy and system change. The state agency strategic plan will be supported by both Ms. Gaines and Ms. Lacefield Lewis in a non-voting role to advise the committee about the plan and ongoing implementation.

Ms. Dougherty referenced the handout *Behavioral Health Advisory Committee Travel Reimbursement* provided to members. There is travel reimbursement for adult, youth consumer and peer provider positions. It is a legacy from the previous council in terms of who is authorized to receive travel reimbursement and it is limited by funds available by the block grant. Other funds may become available. Questions can be directed to Ms. Dougherty.

Ms. Magee stated that meetings will be conducted using Robert's Rules of Order as a guide. Bylaws are being developed. Ms. Magee referenced the handout *Terms of Office* and the handout *Block Grant Subcommittee Presiding Officer* provided to members which lists a description of job responsibilities for officers, the Chair and Vice Chair.

Initial terms will be staggered with two-year and three-year terms with three-year terms thereafter. Members drew for their terms, the results of which are as follows:

Member	Term	Term Expires On
Afejuku, Ayo MD	2 year	August 31, 2018
Aylor, Candace	2 year	August 31, 2018
Berrones-Soto, Jr. Leroy	3 year	August 31, 2019
Castaneda, Elizabeth	3 year	August 31, 2019
Feehery, Matthew	2 year	August 31, 2018
Horton, Colleen	3 year	August 31, 2019
Howell, Jason	3 year	August 31, 2019
Humphrey, Cynthia	3 year	August 31, 2019
Johnson, Celeste	3 year	August 31, 2019
Johnson, Windy	3 year	August 31, 2019
Kliewer, John MD	2 year	August 31, 2018
Leon, Carlos	2 year	August 31, 2018
Osadchey, Lidya	3 year	August 31, 2019
Richardson, Andrea	3 year	August 31, 2019
Scott, Nakia MD	2 year	August 31, 2018
Wolff, Matthew	2 year	August 31, 2018
Young, Wayne	3 year	August 31, 2019
Zaragoza, Evelyn	2 year	August 31, 2018
Consumer (Vacant)	2 year	August 31, 2018

Ms. Gaines answered questions about term limits and the process for resignation. If a member needs to resign from the Committee, they can send in their resignation. There is nothing to dictate what part term limits will have on election of officers. The Committee will establish a subcommittee to help elect the chair and the subcommittee can bring term limits for officers back as a recommendation.

Action Item:

- Ms. Magee will send out an email with the terms for each of the members.

Agenda Item 6: Health and Human Services Behavioral Health and Transformation overview

Health and Human Services staff referenced the PowerPoint handout and presented updates on the transformation.

- **Department of State Health Services**

Ms. Lacefield Lewis presented on the *Mental Health and Substance Abuse Division*.

Action Item:

- Ms. Lacefield Lewis will provide the breakdown of dollar amounts for the funding sources for fiscal year 2016 in general revenue and federal funds for mental health and substance abuse.
- Ms. Dougherty will provide the number of clients on an interest list for services statewide.
- DSHS will provide a solid description of capacity and gaps for substance use disorder services as well as an opportunity for broader description of recovery supports.

- **Health and Human Services Medicaid**

Ms. Michelle Erwin, Medicaid/CHIP Program, HHSC, presented about the state Medicaid and Children's Health Insurance Program (CHIP).

Action Item:

- Ms. Erwin will look into the process that happens when an incarcerated person is released and needs Medicaid benefits reinstated.

- **Department of Family and Protective Services**

Ms. Kaysie Reinhardt, Director of Foster Care Redesign and the Public Private Partnership for Child Protective Services (CPS), Department of Family and Protective Services (DFPS), and Ms. Melanie Cleveland, Director of Placement Services for CPS along with the Interstate Compact and the Foster and Adopt Division, DFPS, presented information about the program.

Action Item:

- Ms. Cleveland will provide the number of children in RTCs that are looking for placement.
- Ms. Cleveland will provide the length of time children are waiting to leave a psychiatric and a residential treatment facility.
- Ms. Reinhardt will provide information to the Committee about any plans to use ACES.

- **Health and Human Services Commission**

Ms. Gaines presented an overview of behavioral health coordination.

Action Item:

- HHSC will send a link to the BHCC survey to members, which can be forwarded to others to complete as well.
- HHSC will email the website links for mentalhealthtx.org and the National Traumatic Child Network (NTIC).

- **Department of Aging and Disability Services**

Mr. Anthony Jalomo, Local Authorities Section IDD, DADS, presented on some of the DADS behavioral health initiatives. (Reference the PowerPoint *DADS Local Authorities Section IDD Behavioral Health Initiatives: Piecing Together A Better Future.*)

Action Item:

- Mr. Jalomo will provide the 'Mental Health Wellness for Persons with IDD' weblink to members and include the 'Trauma Informed Care for Persons with IDD' link also.
- DADS will find and provide the federal person-first definition for IDD.

- **Department of Rehabilitative Services**

Mr. Davin Davis, Program Specialist for Behavioral Health, Veterans Affairs, and Substance Abuse, DARS, provided a brief overview.

Action Item:

- Ms. Magee will provide Mr. Davis' contact information to members if they would like to contact him regarding questions about eligibility for individuals with a substance use diagnosis.

- **Overview of Transformation**

Joey Reed, Office of Transformation, Policy and Performance, HHSC, referenced the PowerPoint titled *Status Update on Transformation of the Health and Human Services System* and presented on transformation activities.

Action Item:

- Mr. Reed noted member concerns and comments to pass along regarding the prevention programs for substance use disorder being moved to DFPS.
- Mr. Reed requested Ms. Aylor send him an email with the specific details regarding the two advisory committees she expressed concerns about.

Agenda Item 7: Group exercise - Designing objectives

Ms. Marx asked each member to provide one expectation or area for the Committee to focus on.

Round table discussion from members included:

- Mr. Young stated an expectation to provide HHSC with feedback necessary to be able to develop a model behavioral health system that will not drag behind but rather lead the nation.
- Mr. Wolff echoed Mr. Young's sentiments and added while also using available resources.
- Dr. Scott stated advocating for changing the paradigm in the philosophy for how children are cared for in the state to a more holistically-driven way, with emphasis on wellness, family and patient-centered care, and using a more integrative and holistic approach. Instead of medications and therapy alone, using peer-support, nutrition, and exercise, and incorporating those in a comprehensive way for the best treatment for children.
- Mr. Barrones-Soto stated a desire to use simpler words that everyone can understand.
- Ms. Richardson stated a desire for new recommendations for behavioral health with value-based language for how to improve the system of care and using respectful language for families.
- Ms. Osadchey stated that two-thirds of children with mental illness have abuse issues and those issues follow the individual into adulthood. The desire is to shine a light and create an emphasis and focus on prevention of child abuse to succeed in healthier outcomes for children.
- Mr. Leon stated that with a background in law enforcement, so much money is being poured into reactive types of activities instead of preventive activities. For those in jail, that is the mental health those individuals are receiving. As a politician, if there is an understanding of available funding, the committee can brainstorm, but if funding is not there, that may be irrelevant.
- Dr. Kliewer stated a desire to contribute to the cultural transformations that need to take place in the agencies. Work is being done to educate caregivers on recovery, but does not want the recovery model of care to be something for clients but encourage consumers to take the steering wheel or in the driver's seat in a client-driven way by the person seeking services.

- Ms. Celeste Johnson stated agreement with Dr. Kliewer to have shared decision-making for clients. Working in emergency room (ER) services, most mental health clients come in through an ER so housing issues and accessible substance abuse services need to be timely to prevent clients from being readmitted. Making it easier to navigate the system, even for providers, needs to be addressed.
- Ms. Humphrey stated a desire to see the committee elevate the understanding of substance use disorders and brain disease as not a criminal justice issue but as a mental health issue as well as to get a better picture of substance use disorder and its impact across the HHS system.
- Mr. Howell stated a desire to have recovery metrics or a recovery scorecard for recovery. If recovery is a benchmark, then that is a way to facilitate this transformation.
- Ms. Aylor stated the goal that services are safe through system transformations being trauma-informed. Understanding an individual's ACES and returning power back to the individual seeking help is imperative.
- Dr. Afejuku stated that as a provider and an MCO, it is difficult to be on both sides, and help everybody, but then there is the funding. Her goal is to provide outcome-driven evidence-based care, and the right services at the right cost.
- Ms. Castaneda stated excitement that peer-supported services and PIRs have been part of the conversation.
- Mr. Feehery stated the desire to simplify access to services, to achieve service integration, shared coordination, and simplifying access so rubber can meet the road and services may be delivered in a more efficient and coordinated way.
- Ms. Zaragoza stated a desire on this transformation movement to incorporate these systems to have youth-friendly language, and a cultural transformation to have authentic youth engagement as well as cultural engagement.
- Ms. Horton expressed a desire to see the state build a system of mental health, behavioral health, and substance use services that is not only cross-agency coordinated, but where the agencies have joint responsibility and joint accountability for reaching recovery-based goals whether IDD, criminal justice, but in the school system where recovery is the goal.

Agenda Item 8: Public Comment

- Mr. Greg Hansch, Public Policy Director for the Texas Affiliate of the National Alliance on Mental Illness (NAMI) and is a family member of a person with a mental illness. The top three areas he wanted to address are criminal justice system involvement for persons with mental health and substance use disorders, the coverage gap in Texas, and the state hospitals. Suggestions included: increasing access to quality health and behavioral healthcare; increasing use of jail diversion strategies; training for law enforcement; alternatives to incarceration; partnerships among community mental health providers, law enforcement and the local judiciary; Medicaid benefits being suspended rather than terminated, and then reinstated upon a person's release from county jail; access to housing, employment, and medical and mental healthcare; strengthened oversight of jails; coordination between jails and local mental health providers; address solitary confinement is harmful to a person's mental health; and expand Medicaid coverage. Additionally, we need more capacity in our state hospitals, better accessibility, person-centered care, recovery-oriented care, and trauma-informed care, as well as other best practices.
- Ms. Gyl Switzer, Public Policy Director for Mental Health America of Texas. She challenged the committee to become a beacon of transparency and open government and share all meeting documentation on the website. She expressed interest in seeing the members on the committee as well as the other organizations they work

with that would be helpful for advocates. She concluded by saying that housing and substance use disorders are the two most important issues for people with mental illness.

Agenda Item 9: Next steps and closing remarks

Ms. Dougherty referenced the handouts *Terms of Office*, *Block Grant Subcommittee Presiding Officer*, and *Travel Reimbursement* and stated the need to have three volunteers to sit on the Nomination Committee. Ms. Aylor, Ms. Osadchey, and Dr. Kliever volunteered to serve on the Nomination Committee.

Ms. Gaines thanked members for their commitment and honesty throughout the meeting. She stated a desire to receive input about the behavioral health strategic plan from the committee, as well as feedback on a planning grant from SAMHSA for a Certified Behavioral Health Center in Texas that would allow a perspective payment process.

Mr. Young stated his gratitude to members and desire to work together.

Ms. Magee stated that for the draft rules process, HHSC is working with the Legal department and a committee to review them, and the rules and bylaws will be sent out before the next meeting where they will be voted on. The rules will go out for formal public comment and the advisory committee will be informed in order to provide comment on the specific rules.

Meetings are scheduled for the following dates in 2016: April 22, August 12, and October 21.

Action Item:

- Ms. Magee will send out a link for the Committee website listing contact information and affiliations for each of the members.
- Ms. Magee will send a list of contact information for each of the presenters to members.
- Ms. Magee will send CCBHC SAMHSA grant information to members for feedback as needed.
- Ms. Dougherty will send an evaluation about the meeting to all members to complete and return.

PARKING LOT ITEMS:

1. Self-directed service
2. Number of individuals on the YES Interest list (DSHS) (fully Medicaid funded for whole state?) March?
3. Group homes & housing issues
4. MH Parity (with MCOs)
5. Policy (Medicaid)
6. Available / readable cross-data on website.
7. Peer-supports for transition services (DARS) in high school (?) <question about possibility
8. Peers in motivational interviewing
9. Concern w/ moving pregnant women / SA info DFPS (fear of having children removed)

Agenda Item 10: Adjourn

The Committee adjourned at 3:00 p.m.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

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NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Drug Utilization Review (DUR) Board

Number of Members: 18

Committee Status (Ongoing or Inactive): Ongoing Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 1992 **Date to Be Abolished:** N/A

Budget Strategy (Strategies) (e.g. 1-2-4): 2-3-1 **Strategy Title (e.g. Occupational Licensing):** Medicaid Contracts & Administration

Budget Strategy (Strategies): **Strategy Title:**

[State / Federal Authority](#)
[State Authority](#)
[State Authority](#)

[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Select Type	Identify Specific Citation
	TAC 354.2401
	42 USC 1396r-8(g)(3)(A)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$2,667	\$6,000	\$6,000
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$2,667	\$6,000	\$6,000

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$13,000	\$13,000	\$13,000
Number of FTEs	7.0	7.0	7.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$13,000	\$13,000	\$13,000

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$3,917	\$4,750	\$4,750
555 - Federal Funds	\$11,751	\$14,250	\$14,250
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year

	4	4	4
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Committee Description: The Texas Medicaid Drug Utilization Review Board (Board) is established under the authority of Section 4401, 1927(g)(A) of the Omnibus Budget Reconciliation Act of 1990, Section 531.0736 of the Texas Government Code, and Section 1927 9(g)(3) of the Social Security Act. The 84th Texas Legislature, Regular Session, 2015, Senate Bill 200, Section 3.08 merged the Pharmaceutical and Therapeutics Committee (P&T Committee) functions to the Board's responsibilities. In accordance with the 84th Texas Legislature, Regular Session, 2015, Senate Bill 200, Section 3.08, the Board shall develop recommendations for preferred drug list (PDL) to be

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings? Quarterly DUR and P&T typically meet at Public Hearing Room (Room 125), John H. Winters Building, 701 West 51st Street, Austin, TX 78751; the DUR Board is required to meet at least quarterly.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The output of this advisory board is to provide expertise in the fields of medicine and pharmacy to assist the agency with creating and/or modifying criteria and standards pertinent to the out-patient prescription drugs. The board does not produce documents for the agency or the general public. HHSC produces documents which includes recommendation on DUR intervention proposals, clinical edit proposals, retrospective drug criteria, meeting minutes, and agendas for each of the DUR Board's meetings.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

From the January 2016 meeting, the board recommended some changes to the criteria logic for clinical edit proposal and approved all other retrospective DUR proposals. The agency adopted the recommendations from the DUR Board.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Pre-meeting: meeting logistics (room, media, IT support), public and stakeholders notices, monitor advisory email boxes, prepare agenda, review of content of meeting materials submitted by vendors; coordination meeting material printing and delivery to members; communication with the members to establish quorum; review and approval of meeting agenda by the legal team; post meeting material on VDP website.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. Meeting minutes are included for the first combined meeting, which was on April 29. Previous

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

On its website, the agency notifies of the schedules and location of the meetings. On that page the agency also includes information regarding public testimonies either in person or in writing by mail. Additionally, agency created an email box, vdp_advisory@hhsc.state.tx.us, in order for the public to submit their questions and comments regarding the advisory board meeting and material (proposals) that are scheduled to be reviewed at the next meeting. The agency also sends public notice via Gov.Doc to notify the public of the upcoming meeting. For the

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Medical Board; Texas Academy of Family Physicians; Texas Nurse Practitioners; Texas Medical Association; Texas Osteopathic Medical Association; Texas Organization of Rural & Community Hospitals; Texas Pediatric Society; Texas Association of Community Health Centers; Clarity Child Guidance Center; Texas Hospital Association; Texas; Texas Council of Community Centers

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

The retro-DUR interventional letters and the clinical edits that are approved by the Board and adopted/implemented by the agency have resulted in strengthening the required Drug Utilization Reviews program which is aimed to provide safe and effective out-patient prescription services at a reduced cost to the state and to reduce prescription fraud and abuse.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? Yes

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

Medicaid DUR program is federally required. DUR Board was recommended for consolidation with Pharmaceutical and Therapeutics Committee from Sunset Review of 2014. First consolidated meeting was held April 29, 2016. So the PDL recommendations are, now, also a function of the DUR Board which offers the State substantial savings considering the clinical efficacy, safety, and cost effectiveness, and any program benefit associated with a product.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

HHSC relies on the practical and clinical expertise of the DUR Board members in order to establish an ongoing DUR program which is a federally mandated program. These members are practicing physicians from different fields or specialties of medicine, practicing retail and clinical pharmacists, experts in the academia, expert representatives from managed care organizations and a patient advocacy representative. HHSC relies on the DUR Board to make PDL recommendations for the agency that are efficacious, clinically significant, and cost-effective for Medicaid clients.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

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I) Authority

The Texas Medicaid Drug Utilization Review (DUR) Board (Board) is established under the authority of Section 1927(g)(3) of the Social Security Act and Section 531.0736 of the Texas Government Code. In accordance with Section 1927(g)(3)(D) of the Social Security Act, the Board's activities are detailed in an annual report submitted to the Centers for Medicare & Medicaid Services (CMS).

Senate Bill (S.B.) 200 (Section 3.08), 84th Legislature, Regular Session, 2015, amended the Texas Government Code by eliminating the Pharmaceutical and Therapeutics Committee and transferring its functions to the Board. The duties of the restructured Board include: (1) Develop and submit recommendations to the Texas Health and Human Services Commission (HHSC) for the preferred drug list (PDL); (2) Suggest to HHSC restrictions or clinical prior authorizations on prescription drugs; (3) Recommend to HHSC educational interventions for Medicaid providers; (4) Review drug utilization across Medicaid; and (5) Perform other duties that may be specified by law and otherwise make recommendations to HHSC.

II) Function

A) *Application of predetermined criteria and standards.* The Board will perform the following activities:

- I) Recommend medical criteria using predetermined standards for development of retrospective and prospective DUR. Retrospective and prospective DUR will monitor for potential drug therapy problems including:
 - a. Therapeutic appropriateness
 - b. Overutilization or underutilization
 - c. Therapeutic duplication
 - d. Drug-disease contraindications
 - e. Drug-drug interactions
 - f. Incorrect drug dosage or duration of treatment
 - g. Clinical abuse and misuse
- II) Evaluate the use and effect of criteria and predetermined standards in the identification of inappropriate care provided by healthcare professionals with prescribing authority to Medicaid beneficiaries. The goal of the state's DUR program is to ensure drug therapy is appropriate, necessary, and safe while allowing adequate professional discretion.

B) *Develop and review of educational programs and interventions.* The Board will perform the following activities:

- I) Identify and develop educational programs and interventions to improve prescribing and dispensing practices.
- II) Determine the scope and type of educational programs and interventions that most effectively improve the quality of drug therapy.
- III) Evaluate and modify educational interventions and programs on a periodic basis.

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- C) Review and make recommendations to HHSC to develop and maintain the PDL in accordance to Section 531.072 of the Texas Government Code. The Board recommends drugs to the PDL based on their efficacy, clinical significance, cost effectiveness, and safety.
- D) Maintain HHSC/DUR Board Relationship. HHSC is ultimately responsible for ensuring the DUR and PDL program is operational and conforms to all requirements or decision of the Board.

III) Composition

- A) The Board is composed of 18 members. Of the 18 members, 16 are voting members and two are non-voting members.
- B) The composition of the voting members is as follows:
 - D) 15 physicians and pharmacists who:
 - a. Provide services across the entire population of Medicaid recipients;
 - b. Represent different specialties, including at least one each of the following types of physicians: A pediatrician; A primary care physician; An obstetrician and gynecologist; A child and adolescent psychiatrist; and An adult psychiatrist;
 - c. Have experience in developing or practicing under a PDL;
 - d. Have recognized knowledge and expertise in one or more of the following: Clinically appropriate prescribing of outpatient drugs; clinically appropriate dispensing and monitoring of outpatient drugs; Drug utilization review, evaluation, and intervention; and Medical quality assurance; and
 - e. Are licensed and in good standing with the Texas Medical Board or the Texas State Board of Pharmacy and are actively practicing in Texas seeing Medicaid beneficiaries.
 - II) One consumer advocate who represents Medicaid recipients. As voting physicians and pharmacists, the consumer advocate will have access to confidential information, will attend executive session, and will vote on action items presented to the Board.
- C) The composition of the two non-voting members is as follows: one pharmacist and one physician that will represent Medicaid managed care organizations. These members will not access confidential information, will not attend executive session, and will not vote on action items presented to the Board.
- D) A member is required to notify HHSC if the member's licensure status changes or if the member no longer represents the specialty he or she was appointed to represent.

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IV) Board Appointments and Terms

- A) The Executive Commissioner of HHSC (or the designated agent) appoints Board members.
- B) Members of the Board serve staggered four-year terms. Each term expires at the end of the fourth year of the term on August 31.
- C) Members of the Board will be required to complete an annual Conflicts of Interest (COI) form as part of their yearly attestation.
- D) In the case of a vacancy on the Board, the Executive Commissioner (or the designated agent) will appoint an individual representing the same profession to serve the unexpired portion of that particular term.
- E) Reappointments are at the discretion of the Executive Commissioner.
- F) Absence without just cause from three Board meetings in a year grounds for removal.
- G) Applicants may apply to become members of the Board by following the application process on the HHSC website. In the event of a vacancy that occurs within three months of an appointment, the Executive Commissioner may use the same pool of applicants.

V) Meetings

- A) Board meetings will be held at least quarterly at a time and place to be specified by HHSC Vendor Drug Program staff. The meeting time and place will be published in the *Texas Register* at least one week prior to the meeting. Board meetings are open to the public unless confidential information is discussed, in which case the Board will meet in executive session.
- B) Executive sessions in which confidential information is discussed are not open to the public or to the managed care Board representatives.
- C) The state's recording of a meeting will be the only formal recording of the activities of the Board meetings.
- D) Nine members (voting and non-voting) of the Board at a called meeting constitute a quorum. If quorum is not reached, a meeting will not be held. Nine voting members must be in attendance in order for the Board to vote on action items.
- E) A quorum may be established by teleconference. If nine voting members are at the meeting location, a member may participate via teleconference in very limited circumstances as approved by HHSC VDP staff, and the proceedings are subject to special requirements set forth in the Texas Open Meetings Act. Teleconferencing is never to routinely take the place of physical attendance.

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VI) Board Officers

- A) The Board, in open session, will elect the chair of the Board (Chair) for a term of two years. The Chair must be physician and a voting member.
- B) The Board will elect a Chair every two years during the first meeting of the Board of that state fiscal year (i.e., first meeting that occurs after September 1).
- C) The Board, in open session, will elect the Vice-chair of the Board. The vice-chair must be a voting member.
- D) Chair or Vice-chair vacancies will be elected at first quarterly Board meeting following the vacancy.
- E) Election of Chair and Vice-chair requires at least five votes from the membership in attendance at a meeting in which a quorum is present. Nominations will be accepted from the floor by the Chair. Voting members will nominate the Chair and Vice-chair. If no one member receives a simple majority of the votes, the nominee who received the lowest number of votes is dropped, and the members cast votes from the remaining nominees. This procedure is repeated until a nominee receives a majority of the votes.
- F) The Chair, Board, or HHSC staff may make recommendations to the Executive Commissioner regarding the removal of any member of the Board for a cause including:
 - a. Absence without just cause from three Board meetings in a year.
 - b. Wrongdoing or misconduct.
 - c. A finding of fraud, waste or abuse in relation to Texas Medicaid or any other state or federally funded program.
 - d. A violation of an applicable professional code of conduct.
 - e. Violation of the conflict of interest policy, including failure to submit the required COI form annually.
 - f. Loss of license.
 - g. No longer representing the specialty or industry a member was appointed to represent.
 - h. Releasing confidential information to the public.

VII) Responsibilities of Chair and Vice-Chair

- A) The Chair will:
 - I) Preside over meetings of the Board.
 - II) Provide democratic leadership.
 - III) Be sensitive to the views and opinions of members and maintain an atmosphere in which all members have the opportunity to express their views freely.

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- B) The chair may confer with Vendor Drug Program and other HHSC agency staff in:
 - I) Preparing suitable agendas.
 - II) Planning Board activities.
 - III) Establishing meeting dates and calling meetings.
 - IV) Establishing subcommittees and ad hoc committees.
 - V) Appointing Board members to lead and serve on subcommittees.

- C) If the Chair is absent or otherwise unable to perform the functions of the office, the Vice-chair will perform the functions as the Chair. If during meeting both the Chair and Vice-chair are absent, the Board members will designate a temporary Chair.

VIII) Operational Procedures

- A) Board meetings will be conducted in accordance with the HHSC Policy, the Texas Open Meetings Act, and DUR Bylaws. If issues are not addressed in the HHSC Policy, Texas Open Meetings Act, or DUR Bylaws, the Board will follow the current edition of *Robert's Rules of Order*.

- B) A vote of at least five members is required to carry motions duly made and seconded in any official Board meeting.

IX) Public Attendance and Testimony

- A) The Board will permit public comment on any action item under consideration, including any changes to the PDL, the adoption of or changes to drug use criteria, adoption of clinical prior authorization criteria, or drug utilization review retrospective proposals.

- B) Members of the public wishing to testify must follow the testimony registration process on the HHSC internet website. Members of the public who are testifying in person may provide relevant handouts to HHSC staff facilitating the meeting to distribute to Board.

- C) Testimony registration requires providing the name and the address of the person wishing to testify and organization represented. The person must also disclose whether he or she receives any direct or indirect compensation from a drug manufacturer. Testimony may be time-limited at the discretion of the Chair or HHSC as required. To accommodate testimony from a variety of organizations and individuals, testimony may be limited to one individual per organization or drug manufacturer per agenda item.

- D) Members of the public may provide written testimony for consideration by the Board. Written testimony must be submitted to Vendor Drug Program via mail or e-mail within the prescribed time period as indicated on the HHSC internet website. Written comments are not to exceed ten pages.

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E) Audiovisual equipment and promotional or marketing materials are not allowed.

X) Amendments

- A) Amendments to the Board bylaws can be recommended by the Board or HHSC.
- B) Written notice of the proposed amendment(s) will be sent Board members at least ten business days prior to the meeting.
- C) Amendments must be ratified by a majority of the members present at the next scheduled Board meeting at which a quorum is present.

XI) Compensation

- A) Each member of the Board is entitled to a travel per diem as set by legislative appropriation for each day that the member engages in the business of the Board.
- B) Each member of the Board is entitled to compensation for transportation expenses incurred in connection with the member's duties as provided by the General Appropriations Act.

XII) Confidentiality

- A) The Board members will maintain the confidentiality of any information that HHSC deems confidential.
- B) Confidential information includes the names of recipients, providers, or the particular circumstances pertaining to a specific case. A member may not release confidential information to the public. Any proprietary drug, drug pricing, or drug rebate information discussed during the executive session of the Board meeting will be kept confidential.

XIII) Conflict of Interest

- A) Members must comply with Texas conflict of interest laws including Section 354.1941 of the Texas Administrative Code (relating to the DUR Board Conflict of Interest Policy).

XIV) Definitions

1. **Adverse medical outcome**: a clinically significant undesirable effect that occurs as a result of a course of drug therapy.
2. **Appropriate and medically necessary**: drug prescribing and dispensing that conforms with specific criteria and standards.
3. **Appropriate use of generic products**: use that conforms with state product selection laws.
4. **Clinical abuse/misuse**: provider and/or recipient practices inconsistent with sound fiscal, business, or medical practices that result in unnecessary cost to the Medicaid program or in reimbursement for

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services that are not medically necessary, or that fail to meet professionally recognized standards for health care.

5. **Criteria:** the predetermined and explicit elements of drug use, developed by health care professionals, with which aspects of the quality, medical necessity, and appropriateness of drug use may be compared.
6. **Drug-Allergy interaction:** a situation where a drug is prescribed and dispensed to a patient who has experienced in the past or who, as a result of the prescription, experiences an allergic reaction.
7. **Drug-Disease contraindication:** a situation where the prescribing of a drug may have an adverse impact on a patient's disease condition or the therapeutic effect of a medication may be altered by the presence of a disease condition in the patient.
8. **Drug-Drug interactions:** a situation where two or more drugs are taken by a patient leading to effects that are different from those obtained when the drugs are used independently.
9. **Drug rebate:** the Medicaid Drug Rebate Program is a program in the United States that was created by the Omnibus Budget Reconciliation Act of 1990 (OBRA'90). It requires that drug manufacturers have a national rebate agreement with the Secretary of the Department of Health and Human Services (HHS) in order for states to receive federal Medicaid coverage of their products.
10. **Incorrect dosage:** a dosage of drug that lies outside the range specified in the criteria and standards as necessary to achieve therapeutic benefit.
11. **Incorrect duration of drug dosage:** duration of therapy that exceeds or falls short of the recommendations in the criteria and standards.
12. **Overutilization:** the use of a drug in sufficient quantities or for durations that put the patient at risk of an adverse medical result.
13. **Preferred Drug List (PDL):** The Texas Medicaid PDL is a subset of approved products on the Texas Medicaid Formulary. The PDL consists of medications recommended by the Board for their efficaciousness, clinical significance, cost effectiveness and safety for patients.
14. **Prospective Drug Use Review:** a review of drug therapy before a prescription is filled, typically at the point-of-sale or distribution.
15. **Retrospective Drug Use Review:** an ongoing periodic examination of paid claims data and other records to identify patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care.
16. **Robert's Rule of Order:** Short title of a book, written by Henry Martyn Robert, that is intended to be a guide for conducting meetings and making decisions as a group.
17. **Standards:** professionally developed expressions of the range of acceptable variation from a criterion.
18. **State Fiscal Year:** September 1 to August 31.
19. **Therapeutic appropriateness:** drug prescribing and dispensing that is consistent with criteria and standards.
20. **Therapeutic duplication:** the prescribing or dispensing of two or more drugs from the same therapeutic class in overlapping periods of time.
21. **Underutilization:** the use of a drug by a patient in insufficient quantity to achieve a desired therapeutic goal.

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	Meeting Minutes	Meeting Date 04/29/2016

Date:	Friday, April 29, 2016 9:00 a.m.	
Location:	Texas Department of Aging and Disability Services John H. Winters Human Services Complex Room 125 (Public Hearing Room, first floor) 701 W. 51st St. Austin, TX	
Board members present:	<input checked="" type="checkbox"/> Hogue, Robert L. (Chair) <input checked="" type="checkbox"/> Adams, VirGene K. (Vice-chair) <input checked="" type="checkbox"/> Barnes, J. Nile <input checked="" type="checkbox"/> Briggs, Deborah E. <input type="checkbox"/> Clay, Patrick G. <input checked="" type="checkbox"/> Craddock, Deetra S. <input checked="" type="checkbox"/> Dominguez, RoxAnn <input checked="" type="checkbox"/> Ferguson, Laura E. <input checked="" type="checkbox"/> Garcia, Toribio R.	<input checked="" type="checkbox"/> Hillert, Jr., Melbert "Bob" C. <input checked="" type="checkbox"/> Kudisch, Alejandro D. <input checked="" type="checkbox"/> Leibman, Maurice N. <input checked="" type="checkbox"/> Lester, Jill N. <input checked="" type="checkbox"/> Ngo, Thanh hao T. <input checked="" type="checkbox"/> Wakhlu, Sidarth <input checked="" type="checkbox"/> Deshpande, Salil V. <input checked="" type="checkbox"/> Vazhappilly, Joseph J. <input checked="" type="checkbox"/> Borel, Dennis A.
Board members absent:	<ul style="list-style-type: none"> Clay, Patrick G. 	
HHSC staff:	<ul style="list-style-type: none"> HHSC Vendor Drug Program <ul style="list-style-type: none"> Nahid Assadi, R.PH; Maribel Castoreno; Josh Dominguez, Pharm D; Amanda Garner, Pharm D; Jerry Taylor; Andy Vasquez HHSC Medical Director Office <ul style="list-style-type: none"> Mitchel Abramsky, MD. 	
Vendor staff:	<ul style="list-style-type: none"> Xerox-Heritage <ul style="list-style-type: none"> Larry Dent, Pharm D Health Information Designs, LLC.: <ul style="list-style-type: none"> Christina Faulkner, Pharm D; Rebecca Hohensee Magellan Medicaid Administration: <ul style="list-style-type: none"> Chris Andrews, Pharm D University of Texas at San Antonio: <ul style="list-style-type: none"> Jennifer Seltzer, Pharm D 	

1. Call to Order

- Andy Vazquez, Deputy Director of Vendor Drug Program welcomed the members of the DUR board present and introduced the HHSC staff.

2. Election of Chair and Vice-Chair

- Amanda Garner welcomed the DUR board members and asked each member to introduce themselves, and facilitated the election of the Chair and Vice-Chair.
 - Dr. Hogue was nominated and voted as the Chair by the board.
 - Mr. Adams was nominated and voted as the Vice Chair by the board.

3. Approval of DUR Board Bylaws

- Dr. Hogue asked the board for comments on the bylaws:
 - Mr. Adams asked about Items D and E under meeting and establishing quorum.
 - Dr. Garner responded by saying that the HHSC would highly recommend the board members to be present in person and that the teleconference is added as a last resort to establish a quorum if not at all possible for 9 members to present in person for establishing a quorum.

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- Ferguson asked a question about the section "Functions of the Board", specifically Function #2 that reads, in part, "Evaluate the use and effect of criteria and predetermined standards in the identification of inappropriate care provided..." The question was where those predetermined standards come from?
 - Dr. Garner responded the predetermined standards refer to product package insert, national guidelines, and our criteria guides.
- Ferguson asked a question pertaining to number 1 under B: "Develop and review of educational programs and interventions". Typically the sole educational piece has been those educational letters - would this somehow empower the board to develop other things and if there is a budget for that?
 - Dr. Garner confirmed that the agency would like to expand some of the intervention to include academic detailing and other forms of interventions.
- The board approved the bylaws as presented.

4. Retrospective DUR

- Dr. Dent reported on the recent retro-DUR interventions:
 - Chronic Non-cancer pain
 - Depression: Effective Antidepressant Management
- Dr. Dent reported on the outcomes of the following interventions:
 - Anxiolytics and Sedative/Hypnotics
 - Asthma Disease Management
 - Nonsteroidal Anti-inflammatory Drugs (NSAIDs); Drug Use Evaluation
- Discussions:
 - Mr. Boral asked are the cost savings are straight from the cost of drugs or do they include other cost savings.
 - Dr. Dent responded that the savings are associated with each performance indicators that are used for each intervention and the savings are calculated based on the changes in prescribing practices. The results are based on the pharmacy as well as procedural codes data.
 - Dr. Hillert recommended finding a way to factor in the savings associated with reduced hospitalizations of asthma patient due to better disease management.
 - Dr. Dent responded that there are some predictive modeling that he can use in order to estimate the savings associated with asthma disease management and reduced hospitalization.
 - Dr. Barns asked why there were such big difference in the savings of each intervention.
 - Dr. Dent responded depending on the patient population, we may not get as much savings for some of the interventions. For example the savings for Anxiolytics and Sedative/Hypnotics was low because the majority of Medicaid population are children and young adults with fewer anxiety related issues.
 - Dr. Hillert asked if the vendor can evaluate MCO performances on the same denominators as the state.
 - Dr. Dent responded that the MCO medical and prescription data are captured by the vendor and there is potential to offer performance evaluation to the state.
 - Mr. Vazquez informed the board that currently MCO oversight is not on the contract of this vendor and there is not a process in place to unify the retro-DUR interventions and bring back reports showing savings across all plans.
 - Dr. Vazhappilly stated that the report does not reflect how much of these intervention savings are as a result of what the MCOs are already doing.
- Dr. Dent presented two retro-DUR intervention proposals:
 - Diabetes Disease management
 - The board approved this proposal with the following recommendations:

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- Add a link to the Texas Medicaid preferred drug list (PDL) on the letter.
- Include insulins to the performance indicator number nine.
- Diabetes Disease management
- Multiple Drug Therapy Regimen Review (Poly Pharmacy)
 - The board approved this intervention proposals:
 - Follow up the data in 6 months to see what percentage of these patients are high maintenance patients such as transplant patients.
 - Remove the part about Texas Pharmacy Association's MTM pilot program because it has been discontinued.
 - For prescribers' information and to promote the use of MTM programs available nationally, add the links to those MTM websites even though Medicaid does not reimburse for it.
 - For HIV clients do not exclude the antibiotics

5. Prospective Clinical Edit Proposal

- Dr. Faulkner presented Agents for Gastrointestinal (GI) Motility clinical edit proposal which included Amitiza, Linzess, Lotronex, and Movantik with notifications that Amitiza already having an active clinical criteria.
 - The board approved the clinical edit proposal with the following recommendations:
 - Remove question number 6 on the Amitiza clinical edit.
 - Request to check access to GPI codes in addition to GCNs because the MCOs systems may use GPIs instead of GCNs.

6. Retrospective Drug Use Criteria for Outpatient use in Vendor Drug Program

- Jennifer Seltzer, Pharm. D. presented updates on the following products
 - Ivakaftor
 - Leukotrienes Receptor Antagonists
 - Short-acting B2 Agonist Metered Dosed Inhalers
 - Nebulized Bronchodilators
 - Sedative/Hypnotics
 - Tramadol
- The board approved with the following recommendations:
 - Add a comment in the Short-acting B2 agonists to check for concomitant use of both inhaler and nebulizer formulations of the same product.
 - Dr. Ferguson asked, in table 2 of the Sedative/Hypnotics section, reward the statement the use of barbiturates to show that both phenobarbital and secobarbital are indicated only for procedural sedation. Also the procedural sedation it is not given orally so the dosage form under barbiturates should be rechecked.
 - Dr. Briggs asked to add a comment about tramadol and reduced seizure threshold.

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7. Lunch Break (45 minutes)

8. PDL Classes Review

- Public comment on drug classes to be reviewed for the Medicaid Preferred Drug List (PDL).
 - Dr. Hogue reviewed the procedure for public testimony.
 - The following individuals provided testimony to the board and answered questions:

Speaker	Representing	Recommendations
Michelle Puyear	Gilead	Cayston
Mai Duong	Novartis	TOBI PodHaler
Shine-Ann Pai, RRT	Self	All inhaled antibiotics
Dustin Bruette	Self	All inhaled antibiotics
Michael Jameson, MD	Pfizer	Eliquis
Dennis Honda	Daiichi Sankyo	Savaysa
Steven Zona	Janssen	Xarelto
Manoj Panday, MD	Janssen	Xarelto
Larry Gudgel, PharmD	Boehringer Ingelheim	Pradaxa
John Hinze, MD	Self	Eliquis
QuynhChan Doan	Abbvie	Duopa
Karen Nguyen	Allergan	Bystolic
Mark Stahl, MD	Teva	Proair Respiclick
Ed Paiewonsky	Teva	Proair Respiclick
William Howland, MD	Teva	Proair Respiclick
Larry Gudgel, PharmD	Boehringer Ingelheim	Spiriva/ Respimat, Stiolto Respimat, Combivent
Cameron Swift James	GlaxoSmithKline	Advair
Mai Duong	Novartis	Utibron, Seebri
John Williamson	HAEA	All HAE products

Speaker	Representing	Recommendations
Larry Gudgel, PharmD	Boehringer Ingelheim	Jardiance, Synjardy
Humberto Bruschetta, MD	Self	Invokana
Steven Zona	Janssen	Invokana, Invokamet
Tyrone McBayne	Baxalta	HyQvia
Ray Kong	Amgen	Repatha
Dana McCormick	Sanofi	Praluent
Tari Malmgren	Actelion	Tracleer, Uptravi, Opsumit
Michele Puyear	Gilead	Letairis
Karen Nguyen	Allergan	Viberzi
Courtney Walker, PharmD	Novo Nordisk	Tresiba
Tommy Begees, NP	Adapt Pharma	Narcan spray

- Dr. Andrews provided a brief update on new information regarding the drugs under consideration by the board.

9. Executive Work Session

- Dr. Hogue adjourned the public session so that the board could retire to its Executive Work Session.

10. Announcement of Recommendations for Medicaid Preferred Drug List

- Dr. Hogue called on Dr. Andrews to announce the board's PDL recommendations for the drugs reviewed at this meeting.

11. Announcements

- Dr. Hogue announced the date for the next meeting: Friday, July 29.

12. Adjourn

- Meeting adjourned at 4:30 p.m.

Committee Description:

This committee will fulfill an advisory role to the HHSC Executive Commissioner and HHS System agencies on strategic planning, policy, rules, and services related to the use of health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services. The committee will offer recommendations via regularly scheduled meetings and/or verbal or written communication with HHSC staff assigned to work with the committee. The committee will perform other related tasks as requested by the EC.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

The e-Health Advisory Committee is a newly proposed Texas Health and Human Services System Transformation advisory committee.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.
Health information technology, health information exchange systems, telemedicine, telehealth, and home telemonitoring services are comprised of a diverse group of stakeholders. Having the e-Health Advisory Committee facilitates the HHS System's ability to have a more transparent and participatory process for stakeholders to provide input on various HHS-related Health information technology, health information exchange, telemedicine, telehealth, and home telemonitoring services policy.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.
NA

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Intellectual and Developmental Disability System Redesign Advisory Committee

Number of Members: 26

Committee Status (Ongoing or Inactive): Ongoing Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/2013 **Date to Be Abolished:** 1/1/2026

Budget Strategy (Strategies) (e.g. 1-2-4): 2.3.1 **Strategy Title (e.g. Occupational Licensing):** Medicaid Contracts & Administration

Budget Strategy (Strategies): **Strategy Title:**

[State / Federal Authority](#)
[State Authority](#)
[State Authority](#)

[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Select Type	Identify Specific Citation
Admin Code	Government Code, 534.053
Admin Code	Government Code, 534.054
Admin Code	Government Code, 534.104, and 534.110

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$4,670	\$5,838	\$4,670
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$4,670	\$5,838	\$4,670

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$2,335	\$2,919	\$2,335
555 - Federal Funds	\$2,335	\$2,919	\$2,335
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	4	5	4
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Committee Description: Advise HHSC and the Department of Aging and Disability Services (DADS) on the implementation of the acute care services and long-term services and supports system redesign for individuals with intellectual and developmental disabilities. House Bill 3523 (section 534.053) extends the role of the committee by allowing the committee to establish work groups for the purpose of studying and making recommendations on issues the committee considers appropriate. Section 534.104 requires HHSC to consult and collaborate with the committee on the IDD managed care pilot by: identifying private service providers or managed care organizations (MCOs) for the IDD managed care pilots; analyzing information provided by pilot program service providers or MCOs for making recommendations about a system of programs and services for implementation in the future; and, evaluating the progress and outcomes of each pilot program. The committee also has a role in the transition plan (section 534.110) for services between a waiver or ICF and the pilot and with collaborating and consulting on the analysis of providing acute care to individuals within managed care.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? see note #13

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

SB 7 and HB 3523 requires HHSC to consult and and collaborate with committee on the redesign systme and if abolished we would not be following the intent of the law.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Total hours equals time based on 3 staff who support the committee and the five subcommittees. Many of the subcommittees meet monthly.

Intellectual and Developmental Disability System Redesign Advisory Committee Operating Procedures

I. Background and Purpose

The Intellectual and Developmental Disability System Redesign Advisory Committee (Committee), established by Senate Bill 7 of the 83rd Texas Legislature (Regular Session), advises the Texas Health and Human Services Commission (HHSC) and the Department of Aging and Disability Services (DADS) on the implementation of the acute care services and long-term services and supports (LTSS) redesign for individuals with intellectual and developmental disabilities.

SB 7 requires HHSC and DADS to design and implement an acute care and LTSS system for individuals with IDD that supports the following goals:

- Provide Medicaid services to more individuals in a cost-efficient manner by providing the type and amount of services most appropriate to the individuals' needs.
- Improve individuals' access to services and supports by ensuring that the individuals receive information about all available programs and services, including employment and least restrictive housing assistance, and how to apply for the programs and services.
- Improve the assessment of individuals' needs and available supports, including the assessment of individuals' functional needs.
- Promote person-centered planning, self-direction, self-determination, community inclusion, and customized, integrated, competitive employment.
- Promote individualized budgeting based on an assessment of an individual's needs and person-centered planning.
- Promote integrated service coordination of acute care services and LTSS.
- Improve acute care and LTSS, including reducing unnecessary institutionalization and potentially preventable events.
- Promote high-quality care.
- Provide fair hearing and appeals processes in accordance with applicable federal law.
- Ensure the availability of a local safety net provider and local safety net services.
- Promote independent service coordination and independent ombudsmen services.
- Ensure that individuals with the most significant needs are appropriately served in the community and that processes are in place to prevent inappropriate institutionalization of individuals.

II. Authority

- The Committee is authorized and governed by Chapter 533, Government Code, Subchapter C. and
- Texas Government Code Chapter 2110 (State Agency Advisory Committees).
- Texas Government Code Section 2110.008 (Duration of Advisory Committees) does apply to the IDD System Redesign Committee. This Committee is abolished on January 1, 2024 and Sec. 534.053 of the Texas Government Code which created it is abolished.

III. Committee Composition

Texas Government Code Section 534.053 requires the Committee to include stakeholders from the intellectual and developmental disabilities community, including:

1. Individuals with IDD receiving services under a Medicaid waiver program.
Individuals with IDD receiving services under the ICF-IID program, and at least 3 representatives of IDD advocacy organizations.
2. Representatives of Medicaid managed care and non-managed care health care providers, including:
 - A. Physicians who are primary care providers and physicians who are specialty care providers;
 - B. Non-physician mental health professionals; and
 - C. Providers of long-term care services and supports, including direct care workers;
3. Representatives of entities with responsibilities for the delivery of Medicaid long-term services and supports or other Medicaid program delivery, including:
 - A. Representatives of aging and disability resource centers (ADRC) established under the Aging and Disability Resource Center initiative;
 - B. Representatives of community mental health and intellectual disability centers;
 - C. Representatives of, and service coordinators or case managers, from private and public home and community-based services providers serving individuals with IDD; and
 - D. Representatives of private and public ICF-IID providers; and
 - E. Representatives of managed care organizations contracting with the State to provide services to individuals with IDD.
 - F. To the greatest extent possible, the Executive Commissioner (HHSC) and the Commissioner DADS) shall appoint members to this advisory committee who reflect the geographic diversity of the state, including members representing rural Medicaid program recipients.

IV. Membership

- The Committee Chair (referred to in SB7 as the presiding officer) is appointed by the HHSC Executive Commissioner.
- Committee members are appointed jointly by the HHSC Executive Commissioner and the Commissioner of DADS.
- Members of the Committee who are Medicaid program recipients or relatives of Medicaid program recipients are entitled to a per diem allowance and reimbursement for travel.
- Members eligible for such reimbursement are subject to rates established in the General Appropriations Act. Staff will assist members in requesting reimbursement. Committee members are responsible for providing the required information.
- Original appointed members will serve staggered three, four and five year terms to be drawn by lot at the first organizational meeting. Members drawing a term they believe they will be unable to serve can exchange the term they drew with another member.

A. Attendance

Members are expected to attend all meetings. A member unable to attend a meeting should notify HHSC staff in advance. Staff will notify the Chair. Members may not send a substitute to attend a meeting in their place.

A member who misses three consecutive meetings will be removed from the Committee by the Chair.

B. Vacancies

In the case of a vacancy for any reason, the Commissioner shall fill the vacancy with a representative of the same membership category to serve the unexpired portion of the term of the vacant position.

C. Responsibilities of Members

All members are expected to:

- Attend meetings;
- Participate in work groups as assigned;
- Review agendas and other information sent by staff prior to each meeting;
- Participate in discussions at meetings;
- Abstain from voting on issues that would provide monetary gain to the member or that could be a conflict of interest; and
- Comply with all ethics policies adopted by HHSC or the Texas Ethics Commission.

V. Work Groups

The Chair may establish work groups as needed to discuss and make recommendations to the full committee on specific issues.

Workgroups will comply with the requirements of the Texas Open Meetings Act.

VI. Meetings

- The Committee will meet at least quarterly or more frequently if the Chair determines it is necessary to meet the Committee's charge.
- The Committee is subject to Texas Government Code Chapter 551 (the Texas Open Meetings Act).
- The Committee may, at the discretion of the Chair, use Roberts Rules of Order as a guide in conducting its business.
- A majority of voting members shall constitute a quorum.
- A 2/3 vote of the Committee voting membership is required for adoption of or amendment to these Procedures.
- For all other business, a simple majority (a majority of those voting) is needed.
- Committee recommendations will be adopted by a simple majority vote on a motion that has been made and seconded.

VII. Miscellaneous

A. Administrative Support

The Commission shall provide reasonable administrative and technical support for Committee activities.

The Commission will provide the accommodations and supports needed by a committee member who is a consumer of IDD services to enable them to fully participate in Committee meetings and activities.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

**Intellectual and Developmental Disability System Redesign
Advisory Committee
Meeting #8 • Meeting Minutes
Thursday, October 29, 2015
10:00 a.m. – 4:00 p.m.**

John H. Winters Building
Public Hearing Room
701 West 51st Street
Austin, Texas 78751

Table 1: Intellectual and Developmental Disability System Redesign Advisory Committee member attendance at the Thursday, October 29, 2015 meeting

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Atkins, Mickey	X		Levine, Linda	X	
Boatright, Clay		X	Litzinger, Amy	X	
Brooks, Lynne	X		Marino, Janet	X	
Broussard, Ricky		X	McCamant, Frank	X	
Carlson, Kay C.	X		Murphree, Susan	X	
Delaney, John P.	X		Payne, Susan	X	
Garnett, Susan	X		Quinby, Mary		X
Gill, Debbie	X		Rummel, Leah	X	
Hidalgo, Gary	X		Smith, Carole	X	
Holt-Reuter, Jillana		X	Southern, David	X	
Hull, Kathryn	X		Tapia, Carl MD	X	
Jimenez, Gerard	X		Wood, Cheri		X
Langendorf, Jean	X		Zwicker, Ivy		X

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 1: Welcome and Introductions

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee (SRAC) meeting commenced with Ms. Susan Garnett serving as chair on behalf of Clay Boatright. Ms. Garnett welcomed participants to the meeting. Table 1 notes committee member attendance at the meeting. It was announced that Jesse Moorhead is the new Department of Aging and Disability Services (DADS) liaison taking Penny Larkin’s place.

Ms. Cassandra Marx noted that a quorum was present.

Agenda Item 2: Committee Chair Update

Ms. Kathi Montalbano noted that the chairs and key staff for the Senate Bill (S.B.) 7 and 58 advisory committees met via conference call. Minutes will be provided to all members when they are approved. Ms. Montalbano shared the work of the IDD SRAC including:

- updates on the S.B. 7 report for input
- the establishment of the new Day Habilitation and Employment Services Subcommittee

- the recommendations of the Housing Subcommittee and the letter submitted to the Texas Department of Housing and Community Affairs (TDHCA) in September
- an update on the assessment tool,
- information on the work and recommendations of the Quality Subcommittee,
- the work of the Transition to Managed Care Subcommittee, and
- the recommendations the committee is to bring forth at the meeting today.

Agenda Item 3: Review and Adoption of July 30, 2015 meeting minutes

Ms. Garnett reminded committee members the minutes from the July 30, 2015 meeting had been distributed via email and that no changes were submitted to HHSC. She asked for any additions, changes, or concerns.

Motion:

Mr. Frank McCamant moved to accept the minutes as written. Ms. Kay Carlson seconded the motion. The minutes were unanimously approved by voice vote with no nays or abstentions.

Agenda Item 4: Public Comments

Ms. Garnett called for public comment. There was no public comment at this time.

Agenda Item 5: Senate Bill 7 Financial Projections Presentation

Ms. Lisa Carruth, Director of System Forecasting, HHSC, referred to the presentation in the packet *Senate Bill 7 Analytical Process*. She discussed the process for financial projections. Highlights of the discussion were as follows.

- Planning can begin as early as right after a session ends, and typically begins in the even numbered fiscal years. S.B. 7 questions involve case load movement, for example, how clients move from fee-for-service to managed care, and the basic costs associated.
- They use historical costs and apply savings, but have to assure they are actuarially sound so the Centers for Medicare and Medicaid Services (CMS) approves them. Additionally, many groups are engaged to ensure that the projection analyses are as accurate as possible.
- Ms. Carole Smith noted that Texas Home Living (TxHmL) was adopted for 2017 and in the last session the date was moved to 2018. For other IDD waivers, the date is 2021. Ms. Carruth noted that those were the dates used for the original analysis.
- As this is regarding state funds under S.B. 7, Mr. McCamant asked if there are additional federal funds that could be utilized due to implementation of managed care. Ms. Carruth noted that there is an additional 6% match for Community First Choice (CFC).
- Mr. McCamant noted that previous discussion on S.B. 7 indicated that once it was implemented, it would clear a lot of the interest list. However, the handout notes that the interest list would be maintained. Ms. Carruth responded that DADS staff would need to respond to that, as the numbers came from them. Mr. David Southern stated that those assumptions were based on a lot of people initially being moved from the interest list to CFC. Additional information regarding this will be addressed during the CFC presentation later in the meeting.
- The 6% match also extends to those moving from the STAR+PLUS waiver to CFC and receiving Personal Assistant Services (PAS). Ms. Carruth stated that numbers on the makeup of individuals receiving the 6% match can be prepared.
- When STAR+PLUS is extended statewide, individuals will come off that interest list for eligibility.

- Mr. McCamant stated that there must be a way to track how many additional people are expected to be served through the different initiatives. The outcome of the initiatives should equate to people being served or taken off interest lists, and must be held to this standard. There must also be a process to see if the actual outcomes met projections. Ms. Carruth noted it is too soon to conduct an accurate saving estimate on things that have recently been rolled out, as there is not enough cost information available.
- Ms. Carruth will check on whether there are assumptions on the 6% for members already served by STAR+PLUS and moving into CFC. Additionally, she will check what is being done with the additional funds. Ms. Garnett wanted follow up to this conversation paying tribute to the ongoing dialogue on legislative appropriation.
- Information was included on the initial costs and savings. The initial estimates showed an overall cost to the system. The Health and Human Services (HHS) system costs are considered the significant revenue generated on premium tax, which nets significant savings to the state. The fiscal note five-year impact showed a positive impact to the state budget of over \$400 million in premium tax.
- The next Legislative Appropriation Request (LAR) is for September 2017 through August 2019, which will cover the period where some things will start to be implemented. With S.B. 7 there are no additional appropriations set aside for the Commission to help with implementation, save for supplemental funding. The dates for which the LAR is prepared will be decided during the new session. It is important for this committee to stay involved in the LAR process and provide input and recommendations around that process.
- Ms. Montalbano will check a document from Ms. Pam McDonald to see whether the money from the 6% match is going back to CFC.

Action Items:

- Ms. Montalbano will add an update on STAR Kids to the next agenda.
- Ms. Carruth will check on the assumptions surrounding the CFC 6% match and will provide that information to the committee.
- Ms. Carruth will check on what is happening with the cost-savings. This conversation will be followed up with at the next meeting.
- Ms. Montalbano will check a document from Ms. Pam McDonald to see whether the money from the 6% match is going back to CFC.
- Ms. Carruth will check on whether there are assumptions on the 6% for members already served by STAR+PLUS and moving into CFC. Additionally, she will check what is being done with the additional funds.

Agenda Item 6: Legislative Appropriations Request Process Presentation

Ms. Montalbano provided an overview of the LAR process. Member discussion highlights are as follows:

- This committee will be kept informed about stakeholder meetings. Also, this committee can submit formal requests to the State Medicaid Director and opportunities for the stakeholder feedback process.
- All requests are reviewed by the agency for what the agency can move forward with.
- If the committee was to write something to the Executive Commissioner, the drop dead date is usually sometime in August (the actual date is unknown until it comes close) in even numbered years. HHSC will be working on base forecasts soon after the first of the year and will look at the LAR forecast, including information on exceptional items and policy changes.

- There will be a lot of changes to the LAR due to movement between agencies, thus, to ensure that deadlines are met, the committee should strongly consider turning items in to compensate for additional time needed in the process.

Action Items:

- Ms. Montalbano will add LAR to the next agenda.

Agenda Item 7: Community First Choice Update

Ms. Chris Welch, Managed Care Lead for implementing CFC, HHSC; Mr. Brian Dees, HHSC; and Ms. Elizabeth Jones, DADS Lead for CFC updated the committee on the progress of the CFC program. They referred to the handout *Community First Choice Responsible Entities for Assessments and Service Delivery*. Highlights of the member discussion were as follows:

Elizabeth Jones – CFC as delivered through the DADS 1915(c) waiver programs

- The proposed rules will be published, with a 30-day public comment period.
- Existing contractors are providing CFC. There are currently minimal provider access issues.

Chris Welch – CFC through MCOs

- Self-reported enrollment numbers as of October 15, 2015: 2,581 members are enrolled in CFC, a little over 1,900 are in assessment process, and 377 have been denied.
- DADS has a role in the level of care assessment and has assessed over 1,300 people: 1,148 were approved, 110 were processed, and 73 were denied.
- There are plans to outreach to individuals on the interest list to find out if they are interested in CFC, and if not, identify the reasons for their decision. There is a desire to find out the reason for the low enrollment numbers. At the next meeting, information will be brought back regarding how many people are on CFC and what happened to them. Also to be reported are the number of significant traditional providers (STPs) contracted and how many chose not to.
- Being denied indicates that the person did not meet the level of care need for that service. However, individuals will remain on the IDD interest list, even if they do not meet the level of care for CFC.
- Ms. Elizabeth Jones will check to see if the assessments for a waiver and CFC are identical, and if the approval decisions would be identical. There are differences in determining eligibility, for example, both programs have different ways of doing income determination. Not meeting CFC does not kick someone off the interest list, and if someone does not qualify because they were on the wrong list, there is a bridge to the more appropriate program so people can get in line for the right waiver.
- There were 10,000-12,000 members identified in the match, who were in both managed care and on the interest list. The assessment process takes a long time, as managed care organizations (MCOs), local intellectual and developmental disability authority (LIDDA), and DADS are all involved, and the agency is working through this list with limited resources. The process takes a lot of time, which is why not all those identified are currently served in the program. Part of the reporting process should provide information as to why people do not participate in CFC and reasons why people were denied. Denied and declined are two different things.
- The first report is due November 6 (covering activity from June until October), and ongoing it will be the previous month's activity reported on a monthly basis to DADS.

- The reports will be forwarded to committee upon completion.
- Mr. Brian Dees, office of policy HHSC, stated that CFC will be implemented for the population currently being served by personal care services (PCS), mainly supplemental security income (SSI) kids who are now in fee for services programs.
- HHSC has been working closely with LIDDAs to establish processes, and things are starting to ramp up. The Department of State Health Services (DSHS) has sent a total of 829 referrals to LIDDAs. As of the previous month a total of 24 have been approved, 1 has been denied, and 5 are awaiting DADS authorization. There were start up challenges, including workload issues, that resulted in a delay.
- Erin Lawler, director of IDD services with Texas Council and Community Centers, let the committee know that a 3 digit code will be assigned to every kind of disposition that can occur when assessed for CFC, such as for enrolled, declined, or denied, with the reasons for being denied and declined having additional code assignments.

Action Items:

- Ms. Jones will check to see if the eligibility assessments for a waiver and CFC are identical, and if the approval decisions would be identical.
- Ms. Jones will check on denials based on assessments and whether if a member is denied for CFC, would they be denied for the waiver.
- Ms. Welch will send report to Ms. Montalbano to share with the committee.
- Ms. Welch will report out on how many people are on CFC and what happened to them. Also to be reported are the number of STPs contracted and how many chose not to.

Agenda Item 8: Lunch

The meeting was recessed at 11:53 p.m. for lunch.

Ms. Garnett called the meeting back to order at 1:07 p.m.

Agenda Item 11: Role of Committee on IDD Managed Care pilot

Ms. Kathi Montalbano reviewed the role of the committee identified under S.B. 3523, 84th Legislative Session, 2015. Since the last meeting, HHSC and its legal department met with DADS about the role of the committee. Ms. Montalbano will check with the HHSC legal department to see what can/cannot be shared with the committee about the pilot, but the hope is to have information to share at the January meeting. Eleven responses were received in response to the Request for Information (RFI) for the pilot and are currently being reviewed. There is use of an outside partner to expedite work on this topic.

The next part of this process includes receiving feedback and identifying next steps. As this is treated as part of the procurement process, Ms. Montalbano will check with the HHSC Legal department to see what can and cannot be shared with the committee about the pilot and the IDD SRACs role with the pilot at the January meeting

Action Item:

- Ms. Montalbano will check with the HHSC legal department to see what can/cannot be shared with the committee about the pilot at the January meeting.
- Ms. Montalbano will check with the HHSC Legal department to see what can and cannot be shared with the committee about the pilot and the IDD SRACs role with the pilot at the January meeting.

Agenda Item 9: Senate Bill 7 2015 Report, Process and Timeline for 2016 Report

Mr. Gary Jessee, HHSC, and Ms. Montalbano presented information regarding the S.B. 7 legislative report drafts, referring to the report template draft and matrix handouts.

- Many of the recommendations shared by the committee were used in some capacity in the changes of the report. Due to the tight timeline for getting the report completed and routed for approval prior to submission, the reports cannot be given back for review at this time. As this report matures and there are more changes in the system, it will become more robust, but is still quite helpful in its present form.
- Changes to the report based on recommendations include expanding on information related to the fiscal assumption piece related to savings; additional information about CFC projections for 2015-2017; obtaining the data for fee-for-service and managed care individuals.
- The brochure will be removed, as it will not be ready in time for the routing of the report. The delay of the pilot was noted, but not as a challenge. Some recommendations received are already being addressed by subcommittees, so will not be listed separately, but as attachments to the report.
- A notice will soon be going out for stakeholder input on what to consider in regards to network adequacy. The agency will also be hosting a forum on S.B. 760 as it relates to network adequacy and current standards. It is too early to report information on the newly implemented CFC.
- Ms. Susan Murphree recommended interim reports for projects that require funding, so that it can provide a broad conceptual framework of the project before the deadline of the project.
- HHSC worked back from the required submission date of September 1, 2016. Mr. Jessee suggested the committee have someone from financial service present on the LAR timeline. Ms. Montalbano noted that Mr. Clay Boatright had thoughts about the report timeline for 2016, and she would speak to him. The desire was also expressed to communicate to Mr. Boatright that the committee was interested in ensuring their involvement and participation in discussion and recommendation related to the LAR.
- The person-centered focus should not be lost in this process.
- Ms. Murphree requested more information regarding the service coordination workgroup and requested it be put on the agenda for a future meeting. While this is early in the process, Ms. Montalbano will bring updates on this back to the committee as a topic for future meetings.

Action Items:

- Ms. Montalbano will take back the recommendation to add an appendix with all the acronyms.
- Ms. Montalbano will talk to Mr. Clay Boatright about the report timeline for 2016.
- Ms. Montalbano will bring updates on the topic of the service coordination workgroup back to the committee as a topic for future meetings.

Agenda Item 10: Health Insurance Premium Program (HIPP) Discussion

Ms. Montalbano noted that historically, those in managed care were not eligible to be in HIPP. Arrangements have been made so that those individuals maintain their HIPP when they are rolled into managed care. S.B. 207 in the last session removed a section from the human resources code now allows for HIPP to be provided for individuals in managed care. As this has not yet been implemented, a closely involved HHSC representative, Tony Owens,

has stated willingness to come talk at January meeting to get feedback on HIPP to help them identify how it will operate in managed care.

Highlights of the member discussion were as follows:

- There is no process to notify people about the HIPP program, but moving forward this will soon be an area of focus.
- Committee members were encouraged to provide feedback at the January meeting of things in the process that were not working optimally, so the representative can have feedback. Anyone with feedback prior to the January meeting is welcome to send it to Ms. Montalbano. A survey is being made to capture the feedback. Many issues need to be worked through before STAR Kids rolls out, as it presents issues unique to the IDD population.

Action Item:

- Ms. Montalbano will have an update on HIPP on the January agenda.

Agenda Item 12: Subcommittee Updates

a. Assessment Tool Subcommittee

Ms. Renee Nolen noted the concerns expressed over the use of only the interRAI IDD assessment, and not multiple ones in the suite, and stated that a follow up was done on this feedback. After discussion with the DADS commissioner, the decision was made to continue using solely the IDD assessment so that there can be an accurate comparison of the tools. After the pilot and evaluation of the assessment are completed, the other assessments will be looked at and brought into the discussion to see if there are gaps and to see if other assessments can be used to fill in those gaps. The purpose of the pilot is to look at the tool and see if it would be something that could be usable statewide, as a better assessment than the ones currently being used.

Although specific dates for the timeframe cannot currently be given, there is an update for where the things are in the process. The Request for Proposal (RFP) has moved over to HHSC and is currently in the hands of Procurement and Contract Services (PCS). It will also go through a Historically Underutilized Business (HUB) review to see if there are opportunities in there for contracting, and then through the legal department. It goes back to DADS for review, and then back to all involved groups until everyone agrees. Following final approval, the RFP will be posted on the ESBD website. Once it is out, HHSC will schedule a solicitation process, with the official questions and answers posted to the website. After the proposals come in there is an evaluation phase that results in the awarding of a contract.

While the RFP process is hard to predict in terms of length of time, it can take anywhere from 6-12 months. A minimum of six months has been estimated for the actual pilot itself.

b. Housing Subcommittee Update

Ms. Kay Carlson stated that the next meeting will be January 27, 2016 and the speaker will be Ashley Sanchez with AIM, a program that is starting in Austin and has been successful in other states. AIM is an independent housing model for people with IDD.

Recommendations were proposed to the full committee, including the suggestion that scenarios be written to illustrate how those recommendations could be put into action. These have been included in the packet for approval, and were referenced.

Motion:

Ms. Carlson moved to approve the recommendations from the Housing Subcommittee and scenarios (with slight modifications and clarifications) and recommend they be included in the S.B. 7 report. Ms. Gill seconded the motion. The motion passed by unanimous voice vote.

c. *Quality Subcommittee*

- The pilot was generated as an agenda topic. The subcommittee is still waiting for direction from HHSC Legal to see how this committee will be involved. There is discussion about having a large interest in the quality of the pilot being conducted and its outcomes.
- A draft form of committee recommendations was brought forward from the Quality Subcommittee, addressing issues such as communication problems and other concerns that have been raised.
- Ms. Garnett noted that HHSC staff should put thought into how to reconcile when committees have recommendations that are in conflict. Discussion was also called for in regards to how this subcommittee interacts with this full committee and other committees that address quality.
- Ms. Garnett stated that the Quality Subcommittee is the right place to start with reconciliation on the different recommendations and recommended that Mr. Boatright give consideration to endorsing this.
- The Quality Subcommittee proposed two recommendations for inclusion in the report. First, all meetings be person-centered and include participants requested by the person. Additionally, coordination issues exist related to communication issues (not related to structural design) and should be addressed as communication issues.

Motion:

Ms. Murphree moved to communicate these two issues to HHSC now as they work to finalize the recommendations from the STAR+PLUS Quality Council. Ms. Gill seconded the motion.

Discussion:

- Ms. Rummel expressed concern over the communication part of the recommendation, as members cannot be serviced without good communication from all parties. Members must be able to connect directly with the health plan. Ms. Janet Marino stated that while the member is responsible and should be inviting who they want for their planning meetings, sometimes they do not know the answers, or are unaware that they have a service coordinator.
- Ms. Murphree identified an action item in figuring out for the IDD full committee and subcommittees, where to focus conversation to address communication issues. According to Ms. Garnett, the subcommittee discussion for transition to managed care has a recommendation regarding communication issues.

With no further discussion, the members voted and the motion carried unanimously via voice vote.

- If low attendance continues with the Quality Subcommittee, decisions will need to be made on how to address quality issues. Understanding and being able to utilize the complaint system in managed care will be addressed at the next

Quality Subcommittee meeting on November 10th. However, if there is not adequate participation, other options may have to be explored to address the issue.

d. Transition to Managed Care Subcommittee

- Ms. Rummel referenced the handout *Transition to Managed Care Subcommittee, Regional Healthcare Collaboration DRAFT Recommendations*. Three recommendations were presented for inclusion in the S.B. 7 report, related to regional collaboration, network access, and education and outreach. The regional collaboration meetings could help address some of the communication issues previously mentioned.
- For issues needing the attention of the Executive Commissioner or this group to resolve, the committee envisioned having a quarterly report of issues that would flow through the full committee. Additionally, having things occur on the local level will help with systemic and day-to-day issues.

MOTION:

- Ms. Rummel moved to approve the 3 recommendations, with a modification to recommendation #1 to add that quarterly systemic issues are to be reported to HHSC and this committee. The motion was seconded by Mr. McCamant. The motion carried with a unanimous voice vote.

e. Day Habilitation and Employment Services Subcommittee

- Ms. Levine discussed the focus of the subcommittee: transportation, Person-Centered Planning (PCP) for day activities and work; employer awareness, keeping benefits, and working and changing benefits and attitudes.
- There is a need to build a better bridge between high school and employment.
- A DADS survey closed last week to gather information on day habilitations (with at least 800 day habilitation providers) in the state. The subcommittee will get more information on this at the next meeting.
- There is a need not only to define a working definition for "fully integrated," but also to determine what constitutes if something is fully integrated.
- As action items, the committee is currently trying to determine the focus of committee. Additionally, the committee is awaiting information from the day habilitation survey from DADS. Ms. Murphree is also going to give input concerning services and rates.
- Information from DADS concerning day habilitation rates (by level or program) and how things are paid was requested as useful information. The rate structure for all programs should be provided. The plan should determine how many days a member goes to day habilitation, not the rate.

Action items:

- Ms. Montalbano will resend subcommittee member list to members.

Agenda Item 13: Discussion of Agenda Items/Potential Topics for January 28, 2016 IDD SRAC Meeting

- HIPP within the managed care environment, Mr. Owens will come discuss this
- LAR Process and how recommendations are made by agencies and participation into the LAR
- Financial Projections used for S.B. 7 outcome
- STAR Kids implementation in the Fall of 2016
- CFC data
- IDD pilot

- Committee Report due September 2016
- HHSC service coordination workgroup, asked for a representative talk about this
- Reconciling recommendations from various groups
- Post-secondary education

Agenda Item 14: Public Comment

Ms. Linda Litzinger expressed the desire to have something in the LAR about employment. There is talk about stopping subminimum wages and sheltered workshops. In order to make this work they need to work with the population. There is a need for, among other things, pilots for consumers to develop more of their own businesses. This process will require money, but is necessary.

Agenda Item 15: Adjourn

The meeting was adjourned by Ms. Garnett at 3:35 pm.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

**Intellectual and Developmental Disability System Redesign
Advisory Committee
Meeting #9 • Meeting Minutes
Thursday, January 28, 2016
10:00 a.m. – 4:00 p.m.**

Brown Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, Texas 78751

Table 1: Intellectual and Developmental Disability System Redesign Advisory Committee member attendance at the Thursday, January 28, 2016 meeting

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Atkins, Mickey	X		Levine, Linda	X	
Boatright, Clay	X		Litzinger, Amy	X	
Brooks, Lynne	X		Marino, Janet	X	
Broussard, Ricky	X		McCamant, Frank	X	
Carlson, Kay C.	X		Murphree, Susan	X	
Delaney, John P.	X		Payne, Susan	X	
Garnett, Susan	X		Quinby, Mary		X
Gill, Debbie	X		Rummel, Leah	X	
Hidalgo, Gary	X		Smith, Carole	X	
Holt-Reuter, Jillana	X		Southern, David		X
Hull, Kathryn	X		Tapia, Carl MD	X	
Jimenez, Gerard	X		Wood, Cheri	X	
Langendorf, Jean	X		Zwicker, Ivy	X	

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 1: Welcome and Introductions

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee (SRAC) meeting commenced with Committee Chair Clay Boatright welcoming participants to the meeting. Table 1 notes committee member attendance at the meeting. Ms. Cassandra Marx noted that a quorum was present.

Agenda Item 2: Review and Adoption of October 29, 2015 meeting minutes

Mr. Boatright referred committee members to the minutes from the October 29, 2015 meeting. Mr. Ricky Broussard requested the minutes be amended to show that he was not in attendance.

Motion:

Mr. Mickey Atkins moved to approve the minutes with the correction to Mr. Broussard's absence. Mr. Broussard seconded the motion. The minutes were unanimously approved by voice vote with no nays or abstentions.

Agenda Item 3: Public Comments

Mr. Boatright called for public comment. There was no public comment at this time.

Agenda Item 7: IDD Managed Care Pilot Update

Ms. Kathi Montalbano provided an update for the managed care pilot. Highlights of the discussion were as follows.

- Leavitt partners is working with HHSC on the pilot project and has assisted with stakeholder forums and will be involved in assisting HHSC with the project including the development of the pilot readiness reviews for the program. There have been four face-to-face stakeholder forums and two webinars set up to obtain feedback on the pilot. Feedback will be reviewed to help with the draft of the proposal.
- House Bill 3523 relates to the role of the committee with the pilot. After meeting with HHSC executive leadership, procurement contract staff, and the legal department, it was determined that in order to maintain the integrity of the procurement process and avoid perceived or actual conflict of interest, the committee will not have a role in identifying candidates or evaluating the managed care proposals, nor will they have a role in any development for the request for proposal (RFP), as this could be a perceived or potential conflict of interest. The committee can evaluate the pilot to make recommendations once the pilot is up and running, and consult and collaborate with HHSC on submitting a report to the legislature about the outcomes of the pilot. The current stakeholder comment period for the pilot has been extended until February 5, 2016. Ms. Montalbano will send out an email address to committee members where comments are being officially received, as well as a link to the gov delivery information where people can sign up for DADS and HHSC electronic notices.
- Members expressed concern with the limited role of the committee. Ms. Montalbano agreed to take their concerns back to leadership. Concerns expressed included:
 - Dr. Carl Tapia said that without individual input, he is worried that the RFP and pilot will not be as effective. Ms. Montalbano reminded members that the forums provide an opportunity for individuals to provide input.
 - Mr. Broussard agreed, saying the ability to have their input heard would help those going through the process to feel more comfortable.
 - Mr. McCammant suggested considering to include public or stakeholder members on the review committee, citing the autism study.
 - Ms. Susan Garnett asked whether potential conflict ended when the contract ended, when the contract is awarded, or whether it extended.
- Mr. Boatright suggested an additional forum be held to solicit input.

Action Items:

- Ms. Montalbano will send out an email address to committee members where comments are being officially received as well as a link to the Gov delivery information where people can sign up for DADS and HHSC electronic notices.
- Ms. Montalbano will also check and see if the committee can get a summary of comments and feedback made during the forums, as they are public record.
- Ms. Montalbano will share committee members' concerns noted above with agency staff.

Agenda Item 3: Health Insurance Premium Program (HIPP) Discussion

Ms. Deborah Keyser and Ms. Melissa Schulle presented an update to address questions from the last meeting. Member discussion highlights are as follows:

- The HIPP program is undergoing a redesign. Senate Bill 2007, 84th Legislature, Regular Session, repealed a section of the code, allowing managed care members to enroll in the HIPP program. In January 2015, the Sunset Advisory Commission recommended to have HIPP transferred from the Office of Inspector Generals (OIG) to HHSC to better integrate services with other Medicaid programs; the transfer occurred in September 2015. Effective September 2014, HHSC implemented a policy change to allow dual enrollment in HIPP and STAR+PLUS and HHSC is currently evaluating changes to get a formal policy in place to allow dual enrollment for HIPP and STAR.
- Next steps in this process include reaching out to other states, identifying best practices, updating the cost effective methodology, and making the process easier to navigate for individuals. There are current plans for marketing and outreach to Medicaid providers, stakeholders, managed care organizations (MCOs), and other users.
- Anyone interested in getting additional information can find it on www.gethipptexas.org. Additionally, there is an email address for people who need more information than is provided on the website, MCD_HIPP_Program@hhsc.state.tx.us.
- During the October meeting a question was raised concerning services provided by Medicaid enrolled providers and non-Medicaid enrolled providers. As this is something not often seen by the department, staff asked that example scenarios be sent to the email address box for further assistance and clarification.
- Ms. Keyser will find out more information about whether someone who is enrolled in HIPP and Medicare, who never really uses HIPP, loses benefits.
- Ms. Rummel suggested the process of providing information be streamlined, as her experience has shown that the third party information provided to Texas Family Institute (TFI) is not being communicated with HIPP.

Action Items:

- Ms. Keyser will find out more information about whether someone who is enrolled in HIPP and Medicare, who never really uses HIPP, loses benefits.

Agenda Item 5: STAR Kids Update

Ms. Kellie Dees updated the committee on the STAR Kids program, referring to power point slides. Highlights of the member discussion were as follows:

- November 1, 2016 is the statewide implementation date for STAR Kids. People will have the option to pick between at least two MCOs in each service delivery area. There have been information sessions and webinars to educate families and providers. There is also a tentative member enrollment schedule. The STAR Kids webpage offers more information, and there is an email address for additional questions.
- The agency has not been seeing as many families as they would have hoped at the information sessions, which members of the committee feel is attributed to the fact that child care is not provided during the sessions.
- Individuals with Medically Dependent Children Program (MDCP) will not be kicked off that program for enrolling in STAR Kids. There should not be a gap in coverage, as there are continuity of care provisions. Mr. Boatright suggested communicating this

to families during transition, perhaps with a letter. Ms. Dees will take back this suggestion.

- There is a new STAR Kids Screening and Assessment Instrument (SK-SAI), which includes a MDCP module. The SK-SAI will be used to assess STAR Kids members for MDCP, rather than the MN/LOC tool that is used today. The SK-SAI tool will also be used to assess need for other services in STAR Kids.
- Ms. Susan Murphree noted that children with IDD are not being treated equitably to adults. She suggested writing a letter to Commissioner Traylor, or endorsing the Children's Policy Council (CPC) to not make children go on an interest list for STAR Kids. It was determined that the Transition to Managed Care subcommittee should discuss this and come up with recommendations. This can be brought back to the committee for discussion in April.
- Ms. Garnett raised the issue of children going across boundaries for care. Ms. Dees stated that the agency understands that it is a big issue and have been talking to MCOs, as they should have adequate network providers. Ms. Garnett wanted to express the importance, so the state could look for ways to impact things, as single case agreements are not really a solution in a lot of cases. Ms. Dees will take back this suggestion.
- Mr. Broussard suggested adding individuals who are over 18 with a disability on the STAR Kids Managed Care Advisory Committee. Ms. Litzinger added that if an 18 year-old could not be found, perhaps someone in their mid-teens may be able to articulate enough to explain their experiences. Ms. Dees will bring back that suggestion.
- The interest list will be maintained for those on the list for MDCP. Additionally, there will be a mechanism for review, with a phone line to contact Maximus, and a service coordination line provided on their ID card. The MCO is the trouble shooter for problems that may occur.

Action Items:

- Ms. Dees will take the suggestion to staff to communicate to families during transition that individuals on MDCP will not be kicked off that program for enrolling in STAR Kids.
- The Transition to Managed Care subcommittee will discuss the issue of children being put on interest lists and the subcommittee will come up with a recommendation to be presented to the full committee at the April meeting.
- Ms. Dees will take back to staff the concern expressed for the state to look for ways to impact things, rather than just single case agreements.
- Ms. Dees will extend to staff the suggestion to add to the STAR Kids Managed Care Advisory Committee individuals who are over 18 with a disability or, if unable to be found, someone in their mid-teens who may be articulate enough to explain their experiences.

Agenda Item 6: Lunch

The meeting was recessed at 12:06 p.m. for lunch.

Mr. Boatright called the meeting back to order at 1:07 p.m.

Agenda Item 9: Community First Choice Update

Mr. Brian Dees provided an update on the Community First Choice (CFC) program.

Highlights of member discussion are as follows:

- To-date, the Department of State Health Services (DSHS) has made 1,400 referrals to local intellectual and developmental disabilities authorities (LIDDAs), 159 referrals

to AxisPoint, 40 to LIDDAs for children needing psychiatric care, with 55 approvals, and 762 switched from Personal Care Services (PCS) to CFC. All of these are Medicaid individuals, although some may also be on a waiver interest list.

- Ms. Amanda Dillon, STAR+PLUS specialist provided high level summary totals for CFC in STAR+PLUS.
- For individuals who have declined services, the agency is improving community outreach efforts and MCOs have developed easy to read brochures that may be in provider offices.
- Anyone with feedback was encouraged to email Ms. Dillon. Ms. Dillon noted that statistical information will be shared once it is completely verified.
- Ms. Elizabeth Jones provided a DADS update on CFC, saying that changes are being made to the Home and Community-based Services (HCS) and Texas Home Living (TxHmL) programs. An assessment is being added to HCS and TxHmL to determine CFC personal attendant services and habilitation (PAS/HAB) benefits, and the state changing PAS/HAB service provider qualifications. Additionally, there are opportunities, such as a web based training on CFC basics for HCS and TxHmL that are available for everyone to view. Additionally, a webinar is being developed to guide people through completing the assessment.

Agenda Item 10: Subcommittee Updates

a. Assessment Tool Subcommittee

Ms. Reneé Nolen and Mr. Justin Babineaux from DADS provided an update. The RFP is in the process of being turned over to the HHSC procurement and contracting services (PCS) and the assessment RFP is currently being reviewed by the legal department. As soon as the review is finished there will be a meeting to look over the edits before going to PCS and beginning the finalization phase for final approval. The RFP will be posted for at least 30 days and then proposals will be evaluated prior to contract negotiations. Mr. Babineaux stated that the agency is in the process of developing an RFP to solicit proposals for a university to review the assessments, so all feedback can be compared to make a decision on what is appropriate. If the assessment is adopted statewide it would take the place of the ICAP or SIB-R. The assessment will be compared side-by-side with no external influence, but it has not been considered whether or not the external evaluators will have access to the other suites during their review. Ms. Nolen will take it back to see if external evaluators will have access to the other suites.

b. Housing Subcommittee

At the last meeting there was no quorum, so the minutes could not be approved. A survey will go out to see how to conduct business. Mr. Spencer Duran did an overview of the 811 rental assistance programs and his notes are included in the packet. There are several million dollars offered through Housing and Urban Development (HUD) and the two percent cap is being utilized. The 811 program is for landlords or buildings and the money is to stay with the property. If individuals are on the minimum supplemental security income (SSI), rent and utilities are in the \$200 range. A project the group is interested in has 681 units, 190 of which are participating. A question was raised as to whether the proposal of benefits should be sent out to each agency for a response.

c. Quality Subcommittee

During the January 21, 2016 meeting, the subcommittee discussed a user-friendly managed care complaint system and training for MCOs regarding working with individuals with IDD. Ms. Murphree stated that they have talked about training in

STAR+PLUS and recommended that the assessment be streamlined.

Mr. Terri Frazier is working on the process and helping the committee come up with a one-pager for the complaint process. Ms. Murphree did not want to make up a program without reaching out to the larger committee and self-advocates, so anyone with feedback for the April meeting is encouraged to do so. Discussing the supported decision-making model will be added to the Quality subcommittee agenda.

d. Transition to Managed Care Subcommittee

Ms. Leah Rummel presented a letter for committee approval for submission to Commissioner Traylor to expand the Network Access Improvement Project (NAIP) program across Texas, as several programs across the state serve kids with special needs. The letter encourages funding for additional training so a broader group of physicians can have expertise; there is a February deadline for submission. According to Ms. Rummel, the funding money comes from the hospital district or a funding entity, and additional funding addresses different sources. Ms. Rummel and Dr. Carl Tapia will send out a list of comprehensive care clinics. Additionally, the committee has been working on recommendations for value added services (VAS) for individuals with IDD. The subcommittee has been looking at other states and collecting information from health plans on meaningful VAS. There is a review of STAR+PLUS packets to ensure that it is more tailored to the population so that it is clearly understood. In the last subcommittee meeting, regional partnerships were reported on. They plan on having more information at the next full committee meeting about the status of the regional healthcare partnerships.

MOTION:

Ms. Carlson moved to send the NAIP letter to Executive Commissioner Traylor.

Ms. Litzinger seconded the motion. The motion passed with a unanimous voice vote.

e. Day Habilitation and Employment Services

Mr. Broussard and Ms. Linda Levine provided an update, saying their first meeting was a conference call and the second was in person. A handout is included in the committee packet. Members have discussed transition and other states' transition processes. A lot of people have transitioned completely and more people are authorized and are receiving services. However, there is a lack of oversight by DADS, as there are at least 800 unregulated day habilitation programs, showing that there are not standards and expectations for day habilitation in Texas. The DADS Sunset Bill, Senate Bill 204, did not pass. This bill contained language related to statutory changes impacting day habilitation programs, including licensing, data collection, etc. The management recommendations related to health and safety of individuals in day habilitation settings, however, were initiated by DADS. Ms. Rummel stated that the Children's Policy Council has regulating day habilitation as a top priority and will have a recommendation. Ms. Garnett stated that the rate structure also needed to be discussed.

Action Items:

- Ms. Nolan will take it back to see if external evaluators will have access to the other suites.
- Ms. Montalbano will figure out the appropriate person to reach out to concerning the proposal of benefits, and Ms. Moorhead will assist on the DADS side.
- Discussion of the supported decision making model will be added to the Quality subcommittee agenda.
- Ms. Rummel and Dr. Tapia will send out a list of comprehensive care clinics.

- Ms. Montalbano will get the bill number regarding day habilitation oversight that did not pass.

Agenda Item 11: Legislative Appropriations Request (LAR) Process and IDD SRAC Recommendations

Mr. David Kinsey, Director of HHS process, provided information about this process, referring to a PowerPoint. Highlights of the member discussion were as follows:

- There is a combination of internal process timelines of what was done last session, although the process may be different this time due to consolidation. The plan is to develop exceptional items and then cross walk that into LARs for the appropriate agencies. In his office, workgroups are set up to ensure that they are coordinating when a request is taken to the legislature. The five agencies are discussing with their key program staff about what their needs will be in 2019.
- The structure will change now that it has moved to a three agency system, and each agency will go through the process.
- Stakeholder meetings in May are to provide feedback on a preliminary or draft list of exceptional items. There is not a defined best mechanism for getting these to appropriate agencies, but Mr. Kinsey suggested that a letter may be appropriate.
- A suggestion came to work on narrowing down the specific dates to get exceptional items. Mr. Kinsey will get confirmation to see if the agencies have determined the specific dates for initial input on exceptional items.
- Subcommittees should get together in February to determine the things they want to be recognized as input from the committee. If the requests can be compiled during February and submitted to the full committee, there could be a meeting to figure out a way to have a committee meeting in March to review them and have them routed to the respective agencies.

Action Item:

Mr. Kinsey will get confirmation to see if the agencies have determined the specific dates for initial input on exceptional items.

Subcommittees should meet in February to determine LAR recommendations.

The full committee will meet in March.

Agenda Item 12: Discuss 2015 and 2016 Legislative Reports and Timeline

Ms. Montalbano presented information on the report and timeline. Discussion highlights were as follows:

- The report has been finalized and has started the routing process. It is being reviewed by executive leadership and once the final report is available it will be shared with the committee.
- Regarding the 2016 report, certain things must be included in the report, but if the committee would like another section included they could put in a request to HHSC on behalf of the full committee.
- To keep with the timeline, at the April meeting the committee would have to discuss the template to see key areas to address in the report. Subcommittees should meet in February to look for areas they would like to submit to the full committee in April. HHSC will then take back the feedback with DADS for the month of May and send it back to the committee in June. All changes would be final at the end of June and routing is to start in July.
- Subcommittees should also see if there is anything beyond that they would like for the agency to include in their annual report. Two agenda items for upcoming

subcommittees should be to talk through LAR recommendations and to discuss the legislative report that may be outside of the LAR request.

Action Items:

- Subcommittees will meet in February to discuss LAR recommendations and suggestions for the annual report.

Agenda Item 6: Post-Secondary Education Subcommittee Discussion

Mr. Gerard Jimenez provided information on post-secondary education. Highlights of the member discussion were as follows:

- There has been a lot of movement in post-secondary education in the past few years, which is good as Texas is behind the curve in offering this to people with IDD. Out of 200 programs in the nation, there are only six available in Texas. Mr. Jimenez founded a program called Access College Texas, and led the legislature to pass it.
- Access College Texas has given 15 presentations across the state and it has become clear that some communities want these sorts of programs.
- To date 82 percent of those who have graduated from a two-year certification program are employed, which is well above the national average of 26 percent.
- The collaborative will have a class for adults with Down's syndrome, as a previous program providing opportunities for original lab research was successful. A small grant was procured to hire two students to be lab assistants and train incoming students in lab procedures as an official part of the UT informal class system.
- Mr. Jimenez said that behavior is the number one challenge in successful inclusion. In their program there is flexibility and creative approaches to addressing issues. Few disability service offices have expertise in providing support for students with IDD, and this program is designed to be super inclusive, but still maintain a few requirements of reading level and age. Cost for the program still remains an issue.
- A recap will be sent to committee members, as well as an email soliciting participation.

MOTION:

Mr. Broussard moved to charter a post-secondary education committee. Ms. Litzinger seconded the motion. The motion passed with a unanimous voice vote.

Action Item:

A recap will be sent to committee members, as well as an email soliciting participation in the newly formed post-secondary education committee.

Agenda Item 13: Discussion of Agenda Items for April 28, 2016 IDD SRAC Meeting

- Group homes and the lack of regulation in the day habilitation program
- Foster care system
- Update on the HHSC transformation system

Agenda Item 14: Public Comment

Ms. Carson stated that the report process is to begin in April.

Agenda Item 15: Adjourn

The meeting was adjourned by Mr. Boatright at 4:02 pm.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

**Intellectual and Developmental Disability System Redesign
Advisory Committee
Meeting #10 • Meeting Minutes
Thursday, March 10, 2016
9:00 a.m. – 12:30 p.m.**

Brown Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, Texas 78751

Table 1: Intellectual and Developmental Disability System Redesign Advisory Committee member attendance at the Thursday, March 10, 2016 meeting

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Atkins, Mickey		X	Levine, Linda	X	
Boatright, Clay	X		Litzinger, Amy	X	
Brooks, Lynne	X		Marino, Janet	X	
Broussard, Ricky	P		McCamant, Frank	X	
Carlson, Kay C.	P		Murphree, Susan	X	
Delaney, John P.		X	Payne, Susan		X
Garnett, Susan	X		Quinby, Mary		X
Gill, Debbie		X	Rummel, Leah	X	
Hidalgo, Gary	P		Smith, Carole	X	
Holt-Reuter, Jillana	X		Southern, David	X	
Hull, Kathryn		X	Tapia, Carl MD	P	
Jimenez, Gerard	X		Wood, Cheri		X
Langendorf, Jean	X		Zwicker, Ivy		X

Yes: Indicates attended the meeting

P: Indicates participated by phone

No: Indicates did not attend the meeting

Agenda Item 1: Welcome and Introductions

The Intellectual and Developmental Disability (IDD) System Redesign Advisory Committee (SRAC) meeting commenced with Committee Chair Clay Boatright welcoming participants to the meeting. Table 1 notes committee member attendance at the meeting.

Ms. Cassandra Marx noted that a quorum was present.

Agenda Item 2: Discuss Housing Subcommittee Legislative Appropriation Request (LAR) Recommendations

Ms. Kay Carlson discussed the Housing Subcommittee LAR recommendations, referring to the handouts. Discussion highlights are as follows:

- Separate the housing transition specialist recommendation from the housing voucher recommendation to make them two separate recommendations.
- In the description of the initiative/issue, the first strategy should read "Create housing transition specialist to assist people with IDD transition to alternative, independent housing locations."
- In proposed solutions, the first paragraph was amended to read, "Funding for housing transition specialists to assist case managers, consumers and families, service coordinators, and low income individuals with IDD transition and housing related services."
- The recommendation on rental assistance had no additional changes.

ACTION ITEMS:

- Ms. Carlson will separate the recommendation about housing transition specialists and housing vouchers so that they are two separate recommendations and make the amendments as discussed.

Agenda Item 3: Discuss Transition to Managed Care Subcommittee Legislative Request (LAR) Recommendations

Ms. Leah Rummel discussed the Transition to Managed Care Subcommittee LAR recommendations, referring to the handouts. Discussion highlights are as follows:

- In the recommendation concerning LAR behavioral health providers, in the critical need that needs to be addressed section, change the third sentence to read, "The challenge is even greater for people who are uninsured or on interest lists..."
- In the recommendation concerning Managed Care subcommittee LAR form 0041-retention, it was recommended that this be broken into three recommendations, and the proposed solutions and recommended course of action can be copied and pasted for each one. Additionally, the description of initiative should include Consumer Directed Services (CDS).

MOTION: Ms. Susan Garnett moved to accept the recommendation.

Ms. Amy Litzinger seconded the motion. The motion carried via unanimous voice vote.

- While the recommendation concerning Network Access Improvement Program (NAIP)/Delivery System Reform Incentive Payment (DSRIP) went to the parking lot for further discussion, no significant changes were made.

MOTION: Ms. Susan Murphree moved to accept the recommendation. Ms. Garnett seconded the motion. The motion carried via unanimous voice vote.

- In the recommendation concerning regional partnerships, it was suggested that the recommendation indicates that the funding is for those meetings. It was suggested that the recommended course of action section mention funding supports.
- The recommendation concerning IDD incentive payments was deleted as it was a duplicate of the recommendation concerning the legislative report template.

- In the recommendation concerning the LAR technology, it was suggested that a sentence be added in the proposed solutions section, that life records are available to consumers and managed care organizations (MCOs), and that this is to be on a shared platform.
- The recommendation concerning the legislative report template was postponed to the April meeting.

ACTION ITEMS:

- Ms. Carole Smith will break out the recommendation concerning managed care subcommittee LAR form 0041-retention, having one non-CDS version and a CDS version.

Agenda Item 4: Discuss Day Habilitation and Employment Service Subcommittee LAR recommendations

Mr. Ricky Broussard discussed the Day Habilitation and Employment Services Subcommittee LAR recommendations, referring to the handouts. Discussion highlights are as follows:

- Compensation for mileage will be added to the recommendation *Day Hab 2 26 update*.
- In the recommendation *Employment 1_ 2 26 Update*, it was noted that in the fourth bullet under recommended course of action, add "create a transition plan to move people currently participating in competitive segregated work environments paying subminimum wage."
- The recommendation *Employment 2_ 2 26 Update* concerning social security administration work incentives brought many changes, including:
 - Recognizing that this recommendation is an expansion of the work that has already been started.
 - In course of action (second bullet), make mention that in order to provide resources and supports, funding is needed. In the first sentence add MCOs (after mention of IDD providers).
 - Add a bullet point to recommend creating a centralized location people can go to for employment related resources (not sure if DARS is still this resource after the transition).
 - Support employment recommendations for a new employment division in HHSC.
 - In recommended course of action (second bullet), add training on how to collaborate with local businesses.
 - Expand/enhance employer recruitment efforts and training as a new bullet.
 - Add a bullet to support employment first taskforce, recommend employment division in HHSC in order to provide resources and support to individuals and families.
- The changes for the recommendation *Self-Determination Initiatives_2 26 Update*:
 - Change the tone of the recommendation from 1st person to 3rd person.
 - Under proposed solutions (fourth bullet), indicate that volunteer positions are an option in addition to employment. Additionally, the term "volunteer" should be changed to "unpaid" and it will be clarified that volunteers do not lose PCP.
 - There may be the need for modification to information concerning the Home and Community-based Services (HCS) waiver.

- Post-secondary education was added to this recommendation, relaying the importance for the state of Texas and HHSC for individuals to support post-secondary education in order to add to their quality of life and fulfillment.
- Under recommended course of action (eighth bullet, third sub-bullet) remove everything after "note" so it reads, "Allow me to decide who works with me, even if I don't fully self-direct my services and even if my staff support me in a group home or other residential service."
- Remove the "STAR+PLUS Waiver Self-direction options" paragraph.
- Add service responsibility option (SRO) to the IDD waiver.

MOTION: Mr. David Southern moved to accept the recommendation. Ms. Smith seconded the motion. The motion carried via unanimous voice vote.

Agenda Item 5: Discuss Quality Subcommittee LAR recommendations

Ms. Murphree led a discussion concerning the Quality Subcommittee LAR recommendations. Member discussion highlights are as follows:

- Changes to the LAR transportation recommendation are as follows:
 - Add as a recommended course of action to commission a comprehensive study of transportation issues, researching the impact on people with IDD. Also add "expand service areas of public transportation," as currently it is required to be ¾ mile from bus line.
 - Case managers should know about other transportation options.
- Changes to the recommendation regarding SRAC Quality oversight are as follows:
 - Ensure that day habilitation services are appropriate and providing approved quality services.
 - Change focus to quality if more money is being requested in day habilitation services.
 - Register all day habilitation services.
 - In description of initiative/issue, need for better services in day habilitation, add "ensure that day habilitation services are appropriately monitored and provide quality services."
 - Add pre-vocational services in critical needs to be addressed.
 - Refer to standards, add minimum requirements for quality; define what makes a good day habilitation.
 - In recommended course of action, first bullet should read "With diverse stakeholder input, create day habilitation standards and add adequate resources that provide incentives."
 - In proposed solutions, add pre-vocational and Community Living Assistance and Support Services (CLASS).
 - Create technical assistance resources, provide high quality.

MOTION: Mr. Southern moved to accept the recommendations. Ms. Jean Langendorf seconded the motion. The motion carried via unanimous voice vote.

- The recommendation concerning SRAC Quality Utilization contained the following changes or alterations:
 - It was suggested that the recommendation ask for funding to support the MCO.
 - There was a suggestion to have the Transition to Managed Care Subcommittee to review these recommendations and HHSC research for the LAR report recommendation.

- Under recommended course of action, change first paragraph to read "Request to implement the following initiatives:"

MOTION: Mr. Southern moved to approve the recommendations. Ms. Litzinger seconded the motion. The motion carried via unanimous voice vote

- The SRAC Quality Assessments and sufficient payments recommendation, the following changes were suggested:
 - In proposed solutions, add "Address barriers for individuals with high needs that result in difficulty accessing home and community based programs and services."
 - In proposed solutions, indicate that if a need is unable to be met, a Home and Community Support Services Agency (HCCSA) is required to disclose their best efforts to the individual and families, as they are required to make available to the state.
 - In sixth paragraph of recommended course of action, the first sentence should read, "Additional effort to provide payments for high medical needs should be implemented across programs..." as they may need to be addressed in CLASS and other programs, as well.
 - In the final paragraph of recommended course of action, drop the examples of need, deleting everything in the sentence after the "such as."
 - Add that before determining whether to make contractors subject to the zero refusal rule, the committee wants to study this further.
- In the recommendation regarding timely access to comprehensive waivers, the following changes were suggested:
 - Under course of action, first bullet, specify "Fund waiting list reduction at least by 10% per year of the biennium."
 - Under course of action, second bullet should read "Fully fund all prompting independence related..."

Agenda Item 9: Public Comment

- Mr. Kyle Piccola, ARC of Texas, provided public comment. He stated that he was there to talk about and offer support for the intent and language around the quality committee recommendation for day habilitation services. For a year and a half the organization has been trying to get a good grasp of the state of day habilitation programs and have encountered both good and really sad programs. Even the really good services are missing the mark to a certain extent, especially with community integration. There has been good conversation about certain regulations, and in order to achieve quality there needs to be an incentive or regulatory bar set so these facilities meet the standards for the people whom they serve. There has also been good conversation around suburban versus rural services and while he understands those areas are underserved, he hopes they can come to this conversation knowing that there is an attainable standard. Technical assistance is key, as is more money, but it is hard to advocate for more money without better quality.

Agenda Item 11: Adjourn

HHSC staff will revise the final LAR submissions to incorporate the language agreed upon by the committee during this meeting.

The meeting was adjourned by Mr. Boatright at 12:41 pm.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
#529 Health and Human Services - Medical Care Advisory Committee

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:

Number of Members:

Committee Status (Ongoing or Inactive): Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: **Date to Be Abolished:**

Budget Strategy (Strategies) (e.g. 1-2-4): **Strategy Title (e.g. Occupational Licensing):**

Budget Strategy (Strategies):

State / Federal Authority
State Authority
State Authority

State Authority
Federal Authority

Federal Authority
Federal Authority

Select Type	Identify Specific Citation
Statute	Chapter 32 of the Human Resources Code,
Admin Code	TAC 1, Part 15, Ch 351, §351.3.(5)(C)
Public Law	Title XIX of the Social Security Act § 1902(a)(4)
Rules	42 CFR 431.12

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$6,708	\$6,708	\$6,708
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$6,708	\$6,708	\$6,708

Committee Members' Indirect Expenses

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$3,354	\$3,354	\$3,354
555 - Federal Funds	\$3,354	\$3,354	\$3,354
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year

	4	4	4
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Committee Description:

Committees.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Each state must have an MCAC as required under federal law- Social Security Act, § 1902(a)(4); 42 CFR §431.12

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

Medical Care Advisory Committee

BYLAWS

August 2012

Texas Health and Human Services Commission
State Medicaid Office

Legal Mandate

The Medical Care Advisory Committee (MCAC) for the State Medicaid Office is established under the authority of Title XIX of the Social Security Act, 42 CFR 431.12, and Chapter 32 of the Human Resources Code (Attachment 1).

Purpose and Role

The purpose of the MCAC is to advise the State Medicaid Director regarding health and medical care services and policies that govern the administration of the Texas Medical Assistance Program (Medicaid). Member representatives will be selected from a broad range of health professionals, consumers, advocacy groups, and individuals with knowledge and expertise that is beneficial to the Medicaid program.

The MCAC advises on policies regarding Medicaid eligibility, health care, and medical services through its review of and recommendations on Medicaid rules with most serious concern for rules impacting accessibility and quality of care. The MCAC's recommendations shall be based on public comment or testimony taken at Committee meetings and the members' own knowledge of and experience with the Medicaid programs involved in the proposed rules. The MCAC has no administrative authority in the operation of the Medicaid program.

The MCAC reports directly to the State Medicaid Director and serves at his/her pleasure. During the course of all meetings, hearings, special sessions, and subcommittee and workgroup activities, the MCAC will be subject to the legal obligations and limitations governing the Commission's rules relating to advisory committees. The State Medicaid Director or designee will be responsible for advising MCAC members of any applicable statutes and regulations.

Composition

Membership

The State Medicaid Office staff solicits nominations from various health professional organizations, consumers, and advocacy groups. The State Medicaid staff reviews and recommends nominees to the State Medicaid Director for appointment. The State Medicaid Director reviews the nominations, consults with the Executive Commissioner of the Texas Health and Human Services Commission, makes the final selection, and appoints members to the Committee. The number of the Membership shall be sufficient to meet the State Medicaid Director's need for sound advice and the directives of authorizing federal and state law.

The commissioners of the operating health and human services agencies appoint standing, non-voting representatives to the MCAC: the Department of Aging and Disability Services, Department of State Health Services, Department of Assistive and Rehabilitative Services, and the Department Family and Protective Services. Additionally, the Health and Human Services Medical Director is a standing non-voting member.

Terms of Membership

Regular members shall be appointed to serve a six-year term. Individuals will normally serve for only one term; however, at the discretion of the State Medicaid Director, an individual may be appointed for a second term. These terms may be served consecutively. The expiration of membership terms occurs on December 31 of each year. To ensure sufficient, appropriate representation, a member serves until his/her replacement has been appointed. The membership will be modified at the direction of the State Medicaid Director.

Replacement Due To Resignation or Death

In the case of a vacancy created by the death or resignation of a member, the State Medicaid Director will appoint an individual to serve the remaining portion of that term. Such individual will be eligible to serve a second term.

Responsibilities of Members

MCAC members are expected to meet certain requirements and perform the following tasks:

1. Attend meetings.
2. Review committee agenda items and the supporting documentation before meetings and participate in discussions.
3. Maintain a level of integrity that warrants public trust.
4. Abstain from voting on any issue that would provide personal monetary gain.
5. Submit travel expenses within 30 days of the meeting.

Responsibility of the Chair

The chairperson shall:

1. Preside at MCAC meetings;
2. Provide democratic leadership;
3. Promote and maintain a participatory environment;
4. Confer with the State Medicaid Director to establish and appoint members to subcommittees and workgroups; and
5. Represent or assure representation of the MCAC at meetings of the Health and Human Services Council and/or other councils as needed.

Responsibility of the Vice-Chair

Perform the same functions as the Chair when the Chair is not present.

Support Staff

The State Medicaid Office MCAC Coordinator will provide support and coordination for all committee activities. This staff person is expected to perform the following tasks:

1. Develop an effective working relationship with members;
2. Solicit nominations for MCAC membership;
3. Act as liaison between MCAC members and operating agencies' staff; and
4. Plan, coordinate, and organize MCAC meetings, subcommittees, and workgroup activities, including:
 - develop agenda and support materials for each meeting;

- prepare and oversee that agenda and support materials are posted in the *Texas Register* in a timely manner; as well as oversee that the MCAC contact information, agendas, and support materials are easily accessible on the HHSC Medicaid website;
- prepare and distribute information and materials for MCAC review;
- document the proceedings of the meetings;
- maintain MCAC records and documentation;
- arrange meetings and meeting sites; and
- assist members with travel arrangements and reimbursement.

Committees

Bi-Annual Election of the Executive Committee

The MCAC will elect a chair, vice-chair, and one additional member from the Committee to comprise an Executive Committee to serve a two-year term. The immediate past Chair of the MCAC and the Chairs of the Hospital Payment Advisory Committee (HPAC) and Physicians Payment Advisory Committee (PPAC) are automatic members and are not elected to the Executive Committee. These automatic members serve two-year terms on the Executive Committee. The Executive Committee will function as a steering committee to the MCAC.

Should a member's term of appointment to the MCAC expire in the middle of that member's term on the Executive Committee, that member's term will be extended an additional year. Elected Executive Committee members may serve multiple terms on the Executive Committee at the pleasure of the MCAC; however, an Executive Committee member on an extended year term is not eligible for another term on the Executive Committee without reappointment as a member of MCAC.

Emergency Meetings

In emergency situations between meetings, the Executive Committee may act on behalf of the entire Committee. Such emergency meetings will be subject to the same open meeting requirements that govern regularly scheduled meetings. The minutes of such emergency meetings will be presented as an agenda item at the next scheduled MCAC meeting for discussion and approval of the membership. In the event the membership does not concur with an action taken by the Executive Committee on behalf of MCAC, in whole or in part, the membership shall take appropriate action in the form of a motion to clarify the position of the MCAC.

"Emergency Situations" can be designated either by the chair of the MCAC, a majority of the Executive Committee, or the State Medicaid Director.

Subcommittees

The Hospital Payment Advisory Committee (HPAC) will be a standing subcommittee of the MCAC. The Chair of HPAC will be a member of the MCAC and will report to the MCAC on HPAC activities.

The Physician Payment Advisory Committee (PPAC) will be a standing subcommittee of the MCAC. The Chair of PPAC will be a member of the MCAC and will report to the MCAC on PPAC activities.

When requested by the State Medicaid Director or the Chair of the MCAC, subcommittees may be constituted. These subcommittees will cease to exist when their assigned tasks are completed.

Election Procedures

The MCAC chair will appoint a Nominating Committee from membership with the advice and consent of the Committee. The Nominating Committee will propose a slate of candidates for officer positions and membership on the Executive Committee. Elections will take place at the last scheduled meeting of the year. Nominations will be solicited from the floor prior to elections.

A member shall be elected to the Executive Committee by a majority vote of the MCAC membership, with a quorum present.

Voting on Executive Committee candidates will be by public vote on the record. If no candidate receives a simple majority of the votes, the candidate who received the lowest number of votes is dropped as a candidate. Members will recast votes on the remaining slate of candidates. This procedure is repeated until a nominee receives a majority of the votes.

Reimbursement

MCAC members will be reimbursed for transportation expenses, lodging, and meals based on the per diem allowed for state employees in accordance with the General Appropriations Act. Receipts for reimbursement and appropriate travel forms must be submitted to the MCAC Coordinator within 30 days.

Meetings

Frequency of Meetings

Regular MCAC meetings are held during regular business hours to coincide with HHS Councils' schedule in accordance with state and federal law.

One over 50% of the voting MCAC members at a called meeting shall constitute a quorum. If less than a quorum of the Committee is present, action items may not be voted upon, although testimony and public comments may be taken. The majority of the members present may adjourn the meeting. The act of the majority of the members present at a meeting at which a quorum is present shall be the act of the Committee.

Meeting Procedures

Meetings will be conducted in accordance with Robert's Rules of Order.

Revisions

MCAC members or the State Medicaid Director may propose changes to these bylaws. All such proposed changes along with the rationale for the changes should be submitted in writing to staff at HHSC and the MCAC Chair at least 30 days prior to the next MCAC meeting for inclusion in the publication of the agenda in the *Texas Register* and distribution to the members for their consideration. Amendments will be passed and become effective based on a majority vote of a quorum of the MCAC members.

FEDERAL: Social Security Act, § 1902(a)(4); 42 CFR §431.12

Sec. 431.12 Medical care advisory committee.

(a) Basis and purpose. This section, based on section 1902(a)(4) of the Act, prescribes State plan requirements for establishment of a committee to advise the Medicaid agency about health and medical care services.

(b) State plan requirement. A State plan must provide for a medical care advisory committee meeting the requirements of this section to advise the Medicaid agency director about health and medical care services.

(c) Appointment of members. The agency director, or a higher State authority, must appoint members to the advisory committee on a rotating and continuous basis.

(d) Committee membership. The committee must include--

(1) Board-certified physicians and other representatives of the health professions who are familiar with the medical needs of low-income population groups and with the resources available and required for their care;

(2) Members of consumers' groups, including Medicaid recipients, and consumer organizations such as labor unions, cooperatives, consumer-sponsored prepaid group practice plans, and others; and

(3) The director of the public welfare department or the public health department, whichever does not head the Medicaid agency.

(e) Committee participation. The committee must have opportunity for participation in policy development and program administration, including furthering the participation of recipient members in the agency program.

(f) Committee staff assistance and financial help. The agency must provide the committee with--

(1) Staff assistance from the agency and independent technical assistance as needed to enable it to make effective recommendations; and

(2) Financial arrangements, if necessary, to make possible the participation of recipient members.

(g) Federal financial participation. FFP is available at 50 percent in expenditures for the committee's activities

STATE §32.022, Texas Human Resources Code

**§ 32.022. MEDICAL AND HOSPITAL CARE ADVISORY
COMMITTEES.**

(a) The board, on the recommendation of the commissioner, shall appoint a medical care advisory committee to advise the board and the department in developing and maintaining the medical assistance program and in making immediate and long-range plans for reaching the program's goal of providing access to high quality, comprehensive medical and health care services to medically indigent persons in the state. To ensure that qualified applicants receive services, the committee shall consider changes in the process the department uses to determine eligibility.

(b) The board shall appoint the committee in compliance with the requirements of the federal agency administering medical assistance. The appointments shall provide for a balanced representation of the general public, providers, consumers, and other persons, state agencies, or groups with knowledge of and interest in the committee's field of work.

(c) The department shall adopt rules for membership on the committee to provide for efficiency of operation, rotation, stability, and continuity.

(d) The board, on the recommendation of the commissioner, may appoint regional and local medical care advisory committees and other advisory committees as considered necessary.

(e) The board, on the recommendation of the commissioner, shall appoint a hospital payment advisory committee. The committee shall advise the board and the department on necessary changes in hospital payment methodologies for inpatient hospital prospective payments and on adjustments for disproportionate share hospitals that will ensure reasonable, adequate, and equitable payments to hospital providers and that will address the essential role of rural hospitals. The board shall appoint to the committee persons with knowledge of and an interest in hospital payment issues.

Acts 1979, 66th Leg., p. 2349, ch. 842, art. 1, § 1, eff. Sept. 1, 1979. Amended by Acts 1987, 70th Leg., ch. 1052, § 2.01, eff. Sept. 1, 1987; Acts 1989, 71st Leg., ch. 1027, § 10, eff. Sept. 1, 1989.

**Health and Human Services Commission
Medical Care Advisory Committee (MCAC)**

**August 20, 2015
Minutes of Meeting**

Members Present:

Gilbert Handal, MD, Chair
Colleen Horton, Vice Chair
Mary Helen Tieken, RN
George Smith, DO
Donna Smith, PT
Michele Bibby
John Hellerstedt, MD
Doug Svien
Edgar Walsh, R.Ph
Joane Baumer, MD
William Galinsky, HPAC Representative

Members Absent:

Elvia Rios

1. Opening Comments and Introductions – Gilbert Handal, MD, Medical Care Advisory Committee Chair

Dr. Handal called the meeting to order at 9:10 a.m. and based upon the members in attendance, a quorum was present. He welcomed guests.

2. Comments from Kay Ghahremani, Associate Commissioner for Medicaid and Children's Health Insurance Program (CHIP), Health and Human Services Commission (HHSC)

Ms. Ghahremani informed members that Charles Smith has joined HHSC as the Chief Deputy Executive Commissioner. Mr. Smith will oversee the consolidation of functions and divisions across the health and human services enterprise as directed by Sunset legislation. She reported that ICD-10 new diagnosis codes will implement October 1, 2015 and HHSC is urging providers to test through Texas Medicaid and Healthcare Partnership to ensure compliance. In addition, all providers are federally required to be re-enrolled in the program by March 2016. HHSC has made changes to make the process easier for providers, though the application process remains lengthy. The agency is urging providers to submit applications prior to March 2016. Ms. Ghahremani reported that there would be an August 31, 2015 public hearing on the therapy reimbursement rules. She ended by announcing that HHSC has implemented a medical benefits process which will help make the determination of benefits more transparent and understandable to the public. She invited attendees to look at the agency website <http://www.hhsc.state.tx.us/medicaid/> for more information.

3. Approval of June 9, 2015 meeting minutes

Dr. Smith moved for approval.

Ms. Mary Helen Ticken seconded the motion.

The motion to approve the minutes passed unanimously.

NOTICE OF PROPOSED RULES/ACTION ITEMS:

4. Managed Care Organization Requirements Concerning Out-of-Network Providers, Rudy Villarreal, Director, Health Plan Management, HHSC

HHSC proposes to amend Title 1, Part 15, Chapter 353, Subchapter A, §353.4, Managed Care Organization Requirements Concerning Out-of-Network Providers.

Nursing facility services were carved into Medicaid managed care effective March 1, 2015. As a result of this change, HHSC is clarifying rule language to mirror managed care contract requirements related to reimbursement of nursing facility services. Additionally, HHSC is taking this opportunity to clarify and add new language related to emergency and non-emergency transport services. Other non-substantive changes are made throughout the rule.

TESTIMONY:

Scott Kibbe, Texas Health Care Association (THCA), provided written testimony neutral on the rule.

Gklizicki Sprinkle, Texas Ambulance Association provided oral testimony in support of the rule.

Referring to subsection (b)(2), Ms. Horton asked for an explanation of the term "timely." Mr. Villarreal responded that the Texas Department of Insurance controls the particular time frame, noting that the managed care organizations have three days to process a prior-authorization request.

Referring to proposed language in the same subsection stated above, Dr. Handal requested staff to clarify language regarding the criteria for out-of-network providers. Mr. Villarreal said the staff would look at the wording before the rule went out.

Action on Item 4

Ms. Ticken moved to approve the rule.

Mr. Galinsky seconded the motion.

The motion to approve the rule passed unanimously.

5. Medicaid Fee-For-Service Drug Reimbursement, Andy Vasquez, Deputy Director, Vendor Drug Program, HHSC

HHSC proposes to amend Title 1, Part 15, Chapter 355, Subchapter J, Division 28, §355.8541, Legend and Non-legend Medications; §355.8546, Brand-Name Drugs; §355.8547, Reimbursement for Compound Prescriptions; §355.8548, 340B Covered Entities; and §355.8551, Dispensing Fee. HHSC proposes to repeal Title 1, Part 15, Chapter 355, Subchapter J, Division 28, §355.8545, Texas Maximum Allowable Cost.

The 2014-15 General Appropriations Act (Senate Bill (S.B.) 1, 83rd Legislature, Regular Session, 2013, Article II, HHSC, Rider 51) requires HHSC to achieve cost savings through initiatives in the Vendor Drug Program (VDP). Also, in a proposed Medicaid Pharmacy Outpatient Rule published by the Centers for Medicare and Medicaid Services (CMS) (CMS-2345-P) to amend 42 Code of Federal Regulation Part 447, subpart I, published on February 2, 2012, CMS proposes to replace estimated acquisition cost with actual acquisition cost as the basis for state Medicaid pharmacy ingredient cost reimbursement. Based on the CMS proposal and a contractor study of Texas pharmacies' drug acquisition costs initiated by HHSC in response to the CMS proposal, HHSC is proposing changes to how acquisition costs are determined and establishing two new acquisition costs: long term care pharmacy acquisition cost and specialty pharmacy acquisition cost. The proposed change from estimated acquisition cost to actual acquisition cost is expected to achieve a cost savings for the state. The proposed rule amendments also include updates to outdated language.

Mr. Galinsky asked if the proposed rule contained a tool to increase the dispensing fee. Mr. Vasquez explained that a method to increase the fee in the rule has not been made. This dispensing fee has a fixed amount of \$7.93 plus a 1.96 percent of the ingredient cost which means the higher the drug price, the higher the dispensing fee. This method provides a mechanism to revisit the fee as drug prices change. To allow for a real wholesale methodology change, a study would be needed in a few years to amend the fee. Mr. Galinsky noted he was in favor of the proposed rule.

Action on Item 5

Ms. Bibby moved to approve the rule.

Dr. Baumer seconded the motion.

The motion to approve the rule passed unanimously.

6. Reimbursement for Certain Drugs in Disasters; Medicaid Fee-For-Service Drug Reimbursement, Andy Vasquez, Deputy Director, VDP, HHSC

HHSC proposes to amend Title 1, Part 15, Chapter 354, Subchapter F, §354.1835, Prescriber Identification Numbers; §354.1851, Substitution of One Drug for Another in a Prescription; §354.1863, Prescription Requirements; and §354.1901, Pharmacy Claims; §354.1921, Addition of Drugs to the Texas Drug Code Index; §354.1923, Review and Evaluation; and §354.1927, Retention and Deletion of Drugs.

HHSC proposes new Title 1, Part 15, Chapter 354, Subchapter F, §354.1868, Exceptions in Disasters.

Reimbursement for Certain Drugs in Disasters

S.B. 460, 84th Legislature, Regular Session, 2015, §1 (to be codified at Texas Health and Safety Code §483.047(b-1)), allows a pharmacist to dispense a 30-day supply of a prescription drug in a Governor-declared disaster without an original prescription under certain conditions. HHSC proposes to amend §354.1835, Prescriber Identification Numbers; §354.1863, Prescription Requirements; and §354.1901, Pharmacy Claims, to allow pharmacists to fill a 30-day supply of medications in certain disaster situations, as allowed by S.B. 460. The amendments also include non-substantive changes. HHSC proposes new §354.1868, Exceptions in Disasters, to clarify that HHSC will reimburse pharmacists for medications dispensed under the conditions described by S.B. 460.

Managed care organizations in Medicaid and CHIP must also adhere to proposed 1 TAC §354.1868, in accordance with 1 TAC §353.905(i), Managed Care Organization Requirements, and 1 TAC §370.701, Applicability of Medicaid Managed Care Standards for Outpatient Pharmacy Services to CHIP.

Medicaid Fee-For-Service Drug Reimbursement

The 2014-15 General Appropriations Act (S.B. 1, 83rd Legislature, Regular Session, 2013, Article II, HHSC, Rider 51) requires HHSC to achieve cost savings through initiatives such as increasing efficiencies in the VDP. Also, in a proposed Medicaid Pharmacy Outpatient Rule published by CMS (CMS-2345-P) to amend 42 CFR part 447, subpart I, published on February 2, 2012, CMS proposes to replace estimated acquisition cost with actual acquisition cost as the basis for state Medicaid pharmacy ingredient cost reimbursement. Based on the CMS proposal and a contractor study of Texas pharmacies initiated by HHSC in response to the CMS proposal, HHSC is proposing changes to how acquisition costs are determined and establishing two new acquisition costs that are based on National Average Drug Acquisition Cost, long term care pharmacy acquisition cost, and specialty pharmacy acquisition cost, to reimburse drug claims submitted by long term care pharmacies and specialty drug pharmacies. The proposed change from estimated acquisition cost to actual acquisition cost is expected to achieve a cost savings for the state. The proposed rule amendments also include updates to outdated language.

Dr. Smith commended the state on the proposed rules.

Action on Item 6

Dr. Smith moved to approve the rule.

Ms. Tieken seconded the motion.

The motion to approve the rule passed unanimously.

7. Medicaid Drug Utilization Review Board, Andy Vasquez, Deputy Director, VDP, HHSC

HHSC proposes to amend Title 1, Part 15, Chapter 354, Subchapter F, §354.1832, Prior Authorization Procedures; and §354.1924, Preferred Drug List.

HHSC proposes to repeal Title 1, Part 15, Chapter 354, Subchapter F, §354.1928, Pharmaceutical and Therapeutics Committee; §354.1941, Conflict of Interest Policy. HHSC proposes as new Title 1, Part 15, Chapter 354, Subchapter F, §354.1941, Drug Utilization Review Board; §354.1942, Conflict of Interest Policy.

S.B. 200, 84th Legislature, Regular Session, 2015, §3.08, requires HHSC to eliminate the Pharmaceutical and Therapeutics Committee and transfer its functions to the existing Drug Utilization Review (DUR) Board. The proposed amendments, repeals and new rules facilitate the elimination of the Pharmaceutical and Therapeutics Committee and transfer of its functions to the DUR Board. All references to the Pharmaceutical and Therapeutics Committee are deleted and replaced with the DUR Board.

Action on Item 7

Mr. Walsh moved to approve the rule.

Dr. Baumer seconded the motion.

The motion to approve the rule passed unanimously.

8. Medicaid Drug Utilization Review Board; Drug Clinical Prior Authorization, Andy Vasquez, Deputy Director, VDP, HHSC

HHSC proposes to amend Title 1, Part 15, Chapter 353, Subchapter J, §353.903, Definitions; §353.907, Prior Authorization Requirements.

S.B. 200, 84th Legislature, Regular Session, 2015, §3.08, requires HHSC to eliminate the Pharmaceutical and Therapeutics Committee and transfer its functions to the existing DUR Board. Both of these rules make reference to the Pharmaceutical and Therapeutics Committee. Also, CMS requires HHSC to have a drug utilization review program, which conducts prospective and retrospective utilization review of prescriptions. Currently, HHSC's definitions of prospective and retrospective utilization review processes are not aligned with similar definitions used by other payers, which is confusing to providers and HHSC's contracted managed care organizations. HHSC proposes to amend these rules to remove all references to the Pharmaceutical and Therapeutics Committee and replace them with DUR Board and to clarify HHSC's Medicaid and CHIP drug utilization review definitions so that the definitions are more closely aligned with other payers' definitions.

There was discussion about pre-authorization criteria and exceptions in regard to special needs pharmacy patients. Dr. Walsh added that there needs to be a method of identifying the patient and prior authorizations as he/she moves through different MCOs and/or situations. Mr. Vasquez asked members to report incidents to HHSC and stated he would take these topics back to staff for discussion.

Action on Item 8

Dr. Baumer moved to approve the rule.

Mr. Walsh seconded the motion.

The motion to approve the rule passed unanimously.

9. Vendor Drug Program, Audit Appeals, Andy Vasquez, Deputy Director, VDP

HHSC proposes to amend Title 1, Part 15, Chapter 354, Subchapter F, Division 5, §354.1891, Vendor Drug Providers Subject to Audit.

S.B. 207, 84th Legislature, Regular Session, 2015, §11 (to be codified at Texas Government Code §531.1203(a)), clarifies that a pharmacy has a right to request an informal hearing before HHSC's Appeals Division to contest the findings of an audit conducted by HHSC's Office of Inspector General or an entity that contracts with the federal government to audit Medicaid providers if the findings of the audit do not include findings that the pharmacy engaged in Medicaid fraud. S.B. 207, §11 (to be codified at Texas Government Code §531.1203(b)), also clarifies that in an informal hearing, HHSC Appeals Division staff, assisted by VDP staff, make the final decision on whether the findings of an audit are accurate.

The proposed rule amendment implements the requirements of S.B. 207 and removes a reference to information provided by regional pharmacists and computerized program

management reports because VDP no longer has regional pharmacist staff to run these reports. VDP regional pharmacists conducted desk reviews, so desk reviews will no longer be done in VDP and any references in the rule are struck. The rule amendments apply only to audits conducted in traditional fee-for-service Medicaid.

At the request of members, Mr. Vasquez explained the proposed informal hearing process.

Action on Item 9

Ms. Tieken moved to approve the rule.

Mr. Walsh seconded the motion.

The motion to approve the rule passed unanimously.

10. Community First Choice in Department of Aging and Disability Services (DADS) 1915(c) Waiver Programs, Elizabeth Jones, Consumer Directed Services Policy Lead, Center for Policy and Innovation, DADS

HHSC proposes, on behalf of DADS, rules to implement Community First Choice (CFC), a Medicaid state plan option governed by the Code of Federal Regulations, Title 42 , Chapter 441, Subchapter K, regarding Home and Community-Based Attendant Services and Supports State Plan Option CFC. CFC is authorized by Texas Government Code §534.152 and is governed by HHSC rules in Texas Administrative Code, Title 1, Chapter 354, Medicaid Health Services, Subchapter A, Purchased Health Services, Division 27, CFC.

The proposal makes CFC services available to individuals enrolled in the following 1915(c) waiver programs: Home and Community-based Services; Texas Home Living (TxHmL); Community Living Assistance and Support Services (CLASS); and Deaf-Blind with Multiple Disabilities (DBMD). The proposal makes CFC personal assistance services and habilitation available through both the provider option and consumer directed services option. The proposal defines each CFC service and describes provider qualifications and training requirements for providers of CFC services, licensing or contracting requirements for providing CFC Emergency Response Services, responsibilities of providers and financial management services agencies (FMSAs) in the provision of CFC services, and extends DADS oversight of program providers and FMSAs to include the provision of CFC services. The proposal adds a requirement for certain staff to complete person-centered planning trainings by a specified timeframe.

Because CFC personal assistance services and habilitation, except for transportation, replaces similar services provided by HCS, TxHmL, CLASS and DBMD, the proposal states that a program provider may provide and bill for the waiver program service only if the activity provided is transportation. The proposal adds eligibility criteria for the 1915(c) waiver programs and additional eligibility criteria for CFC. The proposal expands the eligibility criteria for service coordination provided by a local intellectual and developmental disability authority (LIDDA) to include an individual enrolling in CFC services delivered through managed care and requires a LIDDA staff person who provides, supervises or oversees service coordination to complete person-centered service

planning training approved by HHSC within the timeframes specified in the proposal. The proposal also amends rules specific to HCS, TxHmL, CLASS, and DBMD.

Action on Item 10

Ms. Horton moved to approve the rule.

Dr. Baumer seconded the motion.

The motion to approve the rule passed unanimously.

11. Public Comment

No additional public comment was received.

12. Proposed Next Meeting: Dr. Handal announced that the next meeting is scheduled for Thursday, November 6, 2015, at 9:00 a.m., and seeing no further discussion, he adjourned the meeting.

These minutes were approved by the MCAC on November 4, 2015.

**Health and Human Services Commission
Medical Care Advisory Committee (MCAC)**

**November 6, 2015
Minutes of Meeting**

Members Present:

Gilbert Handal, MD, Chair
Colleen Horton, Vice Chair
Elvia Rios
Mary Helen Tieken, RN
George Smith, DO
Doug Svien
Edgar Walsh, R.Ph
Joane Baumer, MD
William Galinsky, HPAC Representative

Members Absent:

Michele Bibby
Donna Smith, PT

1. Opening Comments – Gilbert Handal, MD, Medical Care Advisory Committee Chair

Dr. Handal called the meeting to order at 9:10 a.m. and based upon the members in attendance, a quorum was present. He announced that the agenda items regarding Exceptional Circumstances, Hearing Services, and Potentially Preventable Readmissions and Potentially Preventable Circumstances were withdrawn from the original agenda posted with the Texas Register. Dr. Hellerstedt resigned from the committee effective immediately. It was announced that this would be Dr. Baumer's last meeting as an MCAC member. Dr. Handal expressed his concern with the anticipated number of Texas Medicaid providers in 2016 and the state's obligation to provide access to care. He stated that improvements need to be made to streamline the system and set more reasonable reimbursement rates.

2. Comments from Gary Jessee, Associate Commissioner for Medicaid and Children's Health Insurance Program (CHIP), Health and Human Services Commission (HHSC)

Ms. Lisa Kirsch, Chief Deputy Medicaid / CHIP Director for Policy and the Transformation Waiver presented an update on behalf of Mr. Gary Jessee, the Associate Commissioner for Medicaid / CHIP, who was not able to attend the meeting. She urged providers to re-enroll with the Texas Medicaid and Healthcare Partnership as soon as possible and said that the enrollment deadline is March 24, 2016. She informed attendees that the ten managed care organizations for the STAR Kids program were recently announced. The program is scheduled to start in the Fall of 2016. In addition, Ms. Kirsch reported that HHSC recently submitted to the Centers for Medicare and Medicaid Services a request to extend the 1115 Transformation and Quality Improvement waiver. She said she was confident that the waiver would continue. Finally, Ms. Kirsch mentioned that work is underway to implement the various Health and Human Services (HHS) system consolidation and transformation initiatives that came out of Senate Bill 200 of the 84th

Texas Legislature. One of the initiatives is to look at how the HHS system is organized and find ways to improve on the system to better deliver services to clients.

3. Approval of August 2015, meeting minutes

Dr. Baumer moved for approval.

Dr. Smith seconded the motion.

The motion to approve the minutes passed unanimously.

NOTICE OF INFORMATIONAL ITEMS:

4. Personal Care Services Attendant Minimum Wage. Ross Keenon, Rate Analyst, HHSC

HHSC proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 363, Subchapter F, §363.603 (relating to Provider Participation Requirements). The proposed rule amendment implements the 2016-17 General Appropriations Act (Article II, Special Provisions, House Bill (H.B.) 1, 84th Legislature, Regular Session, 2015), which requires a minimum base wage of \$8.00 for attendant services. This rule applies to personal care services provided under Texas Health Steps.

The Texas Department of Aging and Disability Services (DADS) has already adopted a similar rule change related to this legislation, which became effective on September 1, 2015. HHSC is proposing this rule amendment to ensure that all attendant services have an applicable rule in place, either through HHSC or DADS. HHSC is seeking an effective date of February 14, 2015, which is the earliest the rule could be effective without publishing the rule in the *Texas Register* prior to the meetings of the Medical Care Advisory Committee and HHS Council.

Colleen Horton: can't let something like this go through without making the point that \$8 is not a living wage, especially with the other issues regarding lack of physicians and attendants coming in 2016. Hope the agency will see that the rate needs to be bumped up. Mr. Galinsky asked why the fiscal impact number was drastically lower compared to 2017. Ms. Kirsch responded that the 2015 amount is due to implementation factors for FY2016. Dr. Handal asked that he be quoted. To consider \$8 wage is obscene. Ridiculous attendant wage. Outraged that \$8 is the rate. Mr. Galinsky: how do you get you are going to pay/ spend more money, but have \$8. HHSC: primary goal is that it increases the amount the provider is required to pay the attendant. This was a rate increase requirement.

TESTIMONY:

Sarah Mills, Texas Association for Home Care and Hospice (TAHCH), provided oral and written testimony neutral on the rule.

NOTICE OF PROPOSED RULES/ACTION ITEMS:

5. Reimbursement Methodology. Sarah Hambrick, Senior Rate Analyst, HHSC

HHSC proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 355, Subchapter D, §355.456 (relating to Reimbursement Methodology) to expand the eligibility criteria for add-on payments for Intermediate Care Facilities for Individuals with an Intellectual Disability or Related Conditions (ICF/IID).

Article II of H.B. 1, 84th Legislature, Regular Session, 2015, appropriated funds for an add-on payment to ICF/IID facilities that are providing services to individuals with high medical needs to reside in a non-state operated facility. Currently, eligibility for the high medical needs beds and add-on payment is limited to individuals who have lived in a State Supported Living Center (SSLC) for at least six months prior to referral to a non-state operated facility; have a level of need (LON) which includes a medical LON increase but not a LON of pervasive plus; and have a Resource Utilization Group (RUG-III) classification in the major RUG-III classification groups of Extensive Services, Rehabilitation, Special Care, or Clinically Complex. DADS began this initiative with 24 ICF beds and four providers in January 2015. As of this date, one six-bed provider is no longer participating, leaving 18 ICF/IID beds approved in this initiative for fiscal year (FY) 2015. The appropriations funded add-on payments for 150 ICF/IID beds, including the original 18 ICF/IID beds, for the 2016-17 biennium. It was anticipated the ICF/IID beds for FY 2016 would be filled due to the SSLC closures, however, because there were no SSLC closures, the demand for moving these SSLC residents has decreased. At the same time, the option of an ICF add-on rate might be useful for similar individuals with IDD residing in nursing facilities who want to move to a community setting. This proposed rule expands the eligibility criteria to include not only individuals from a SSLC but also individuals who are living in a Medicaid-certified nursing facility prior to referral to a non-state operated facility. This allows more flexibility to utilize the appropriated funds while also serving individuals identified through the Preadmission Screening and Resident Review (PASRR) process.

Due to the fact that there have not been enough individuals leaving the SSLCs who meet the current eligibility criteria for the high medical need beds and add-on payment to fully utilize the appropriated funds, DADS is expanding the eligibility criteria to include individuals who have lived in a Medicaid-certified nursing facility prior to referral to a non-state operated facility.

HHSC is proposing amendments to this rule to add this new eligibility criterion for the high medical needs beds in ICF/IID facilities in order for such facilities to receive the new add-on payment.

TESTIMONY:

Carole Smith, Private Providers Association of Texas (PPAT), provided written testimony in support of the rule.

Action on Item 5

Mr. Svien motioned to approve the rule.

Ms. Horton seconded the motion.

The motion to approve the rule passed unanimously.

6. Community First Choice (CFC) Revisions. Jennie Costilow, Senior Policy Analyst, Policy Development, HHSC Medicaid/CHIP

HHSC proposes to amend to Texas Administrative Code, Title 1, Part 15, Chapter 354, Subchapter A, Division 27, §§354.1361 (relating to Definitions); 354.1363 (relating to Assessment); 354.1364 (relating to Services and Limitations); 354.1365 (relating to Provider Qualifications); and 354.1366 (relating to Consumer Directed Services and Service Responsibility Option). HHSC proposes new rules §§354.1367 (relating to Person-Centered Service Plan); and 354.1368 (relating to Fair Hearings).

The new rules and proposed rule amendments:

- set forth requirements related to the person-centered service planning process, person-centered service plan facilitators, and the contents of the person-centered service plan;
- add fair hearing rights related to CFC;
- remove "licensed" from personal emergency response services agency, pursuant to Senate Bill 202, 84th Legislature, Regular Session, 2015 as these agencies no longer require state licensure; and add clarity regarding various aspects of the CFC option.

Ms. Horton asked if attendants will be able to transport individuals in personal assistance services (PAS). Ms. Elizabeth Jones, DADS said individuals will have the option of receiving transportation services through the DADS waiver effective December 1, 2015. Transportation will remain under habilitation service however a separate service code was created.

TESTIMONY:

Sarah Mills, TAHCH, provided oral and written testimony neutral on the rule.

Action on Item 6

Dr. Baumer moved to approve the rule.

Mr. Smith seconded the motion.

The motion to approve the rule passed unanimously.

7. Telemedicine in School-based Settings. Laurie Vanhose, Director for Policy Development, HHSC Medicaid/CHIP

HHSC proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 354, Subchapter A, Division 33, §354.1432 (relating to Telemedicine and Telehealth Benefits and Limitations).

The proposed rule amendment is a result of H.B. 1878, 84th Legislature, Regular Session, 2015, which clarifies that physicians shall be reimbursed for telemedicine medical services provided in a school-based setting, even if the physician is not the patient's primary care physician, if certain conditions are met. The proposed amendment updates the Medicaid rule for telemedicine services to reflect the additional requirements outlined in the law.

Ms. Horton expressed concern with the listing of psychotherapy in §354.1432 (1)(A). Psychotherapy isn't always delivered by a medical professional and suggested including telehealth services in the rule. Ms. Vanhose said the state will consider her comment.

Dr. Walsh expressed his concern with the potential of abuse and unintended consequences of the rule. Ms. Vanhose said that HHSC reports telemedicine expenditures to legislature every other year.

There was discussion about the definitions of distant site and patient site. Ms. Erin McManus said the rule proposal doesn't define the sites geographically and that HHSC can consider the comment.

TESTIMONY:

Maureen Milligan, Teaching Hospitals of Texas, provided oral and written testimony neutral on rule.

Michaela Bernacchio, Children's Health System of Texas, provided oral testimony in support of the rule. The committee requested a copy of the System's data.

Dr. Handal asked for HHSC to monitor the usage and provide a report showing the usage. Additionally, he requested Ms. Bernacchio to share Children's Health System of Texas' data on the telemedicine services they've provided thus far. Ms. Bernacchio said a 2014 report could be provided.

Action on Item 7

Ms. Horton moved to approve the rule.

Dr. Baumer seconded the motion.

The motion to approve the rule passed unanimously.

8. Exceptional Circumstances, Laurie Vanhose, Director for Policy Development, HHSC Medicaid/CHIP

Withdrawn from the agenda

9. Suspension of Medicaid Capacity. Bobby Schmidt, Manager, Provider Licensure and Certification, DADS Regulatory Services

HHSC, on behalf of DADS, proposes new requirements under Texas Administrative Code Title 40, Part 1, Chapter 9, Subchapter E, Division 3, §9.218 (relating to Licensure Action and Facility Closure) and Chapter 90, Subchapter H, §90.239 (relating to Notification of Closure) with which an ICF/IID program provider must comply to voluntarily close a facility and to request suspension of a closing facility's certified capacity for up to one year after the facility closes. The proposal also sets forth notice requirements with which an ICF/IID license holder must comply if closing a facility that apply to all closure types. The rule proposals will repeal existing Texas Administrative Code Title 40, Part 1, Chapter 9, Subchapter E, Division 3, §9.218 (relating to Licensure Action and Facility Closure) and Chapter 90, Subchapter H, §90.239 (relating to Notification of Closure).

Action on Item 9

Mr. Smith moved to approve the rule.

Ms. Tieken seconded the motion.

The motion to approve the rule passed unanimously.

10. Trauma-Informed Care Training. Randy Rowley, Manager, Policy, Rules and Curriculum Development Section, DADS Regulatory Services

HHSC, on behalf of DADS, proposes new Texas Administrative Code Title 40, Part 1, Chapter 90, Subchapter C, §90.44 to require an employee hired by an ICF/IID, including a state supported living center, on or after May 1, 2016, to complete trauma-informed care training before working directly with a resident. The proposal is in response to H.B. 2789, 84th Legislature, Regular Session, 2015.

TESTIMONY:

Carole Smith, PPAT, Carole Smith, Private Providers Association of Texas (PPAT), provided written testimony in support of the rule.

Action on Item 10

Mr. Svien moved to approve the rule.

Ms. Tieken seconded the motion.

The motion to approve the rule passed unanimously.

11. Medicaid and other Health and Human Services Fraud and Abuse Program Integrity. Anne Dvorak, Associate Counsel, HHSC Office of Inspector General

HHSC, on behalf of the Office of the Inspector General (OIG), proposes to amend Texas Administrative Code Title 1, Part 15, Chapter 371 (relating to Medicaid and Other Health

and Human Services Fraud and Abuse Program Integrity).

The existing rules in Chapter 371 include various provisions to ensure the integrity of Medicaid and other HHS programs by discovering, preventing, and correcting fraud, waste, or abuse. The rules in Chapter 371 are proposed, amended or deleted to implement various provisions of S.B. 207, 84th Legislature, Regular Session, 2015; and to clarify, update or eliminate obsolete provisions. Primarily, the proposed amendments revise the current process for investigations and provider background checks as mandated by S.B. 207. The amendments also include additional components and clarifications related to management practices and processes of the OIG, provider disclosure and screening, administrative actions and sanctions, and grounds for enforcement by the OIG.

There was discussion about the options providers have at the conclusion of an OIG investigation. Dr. Baumer asked Ms. Dvorak to explore the necessity of the term expunged in §371.1 (17)(A)(ii). She also requested that the term reasonable request in §371.1 (69) be limited to information the provider has control of. Dr. Handal commented on the use of the appropriate setting term in regards to deterring high costs. Secondly, he said he would like to see a list of sanctions and their outcomes listed which assist providers in determining the issues needing attention. Ms. Dvorak thanked committee members for their comments.

TESTIMONY:

Maureen Milligan, Teaching Hospitals of Texas, provided oral and written testimony neutral on rule.

Ms. Ticken asked Ms. Dvorak if OIG has ever imposed a surety bond as a condition of a settlement agreement. Ms. Dvorak said she would research the question and provide a response to the committee.

Action on Item 11

Mr. Walsh moved to approve the rule.

Ms. Horton seconded the motion.

The motion to approve the rule passed unanimously.

12. Day Activity and Health Services and Community Based Alternatives Program.

Becky Hubik, Lead Policy Specialist, DADS

HHSC, on behalf of DADS, proposes to amend Texas Administrative Code Title 40, Part 1, Chapter 48, Subchapter H, §48.2915 (relating to Day Activity and Health Services (DAHS)) to align the eligibility criteria for Title XIX DAHS with the Medicaid state plan requirements used for individuals receiving DAHS through managed care. The proposal also includes the repeal of Chapter 48, Subchapter J.

Ms. Horton asked what will happen to the Medical Assistance only (MAO) population on the CBA interest list. Ms. Kirsch answered that STAR+PLUS maintains interest lists for MAOs.

Action on Item 12

Ms. Ticken moved to approve the rule.

Ms. Horton seconded the motion.

The motion to approve the rule passed unanimously.

13. Public Comment. There was no public comment.

14. Proposed Next Meeting: The next meeting is scheduled for February 18, 2016, at 9:00 a.m.

15. Adjournment. Seeing no further discussion, Dr. Handal adjourned the meeting.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: Palliative Care Interdisciplinary Advisory Council

Number of Members: By statute, no fewer than 15 appointed members. Currently: 18 appointed, 6 ex officio

Committee Status (Ongoing or Inactive): Ongoing Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 12/1/2015 **Date to Be Abolished:** 9/1/2019

Budget Strategy (Strategies) (e.g. 1-2-4): A.1.1 **Strategy Title (e.g. Occupational Licensing):** Palliative Care Program

Budget Strategy (Strategies): **Strategy Title:**

[State / Federal Authority](#)
[State Authority](#)

[Select Type](#) [Identify Specific Citation](#)

Statute	Texas Health and Safety Code Chapter 118, as adopted by Act of May 23, 2015, 84th Leg., R.S. §2 (H.B. 1874)
Admin Code	Sec. 351.827 (Final adoption est. July 1, 2016)

[State Authority](#)
[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$2,500	\$7,000
Personnel	\$0	\$70,000	\$70,000
Number of FTEs	0.0	1.0	1.0
Other Operating Costs	\$0	\$10,500	\$58,000
<i>Total, Committee Expenditures</i>	\$0	\$83,000	\$135,000

	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$83,000	\$135,000
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	0	3	3
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Committee Description: The Palliative Care Interdisciplinary Advisory Council (PCIAC) assesses the availability of patient-centered and family-focused palliative care in Texas and consults with and advises HHSC on matters related to the establishment, maintenance, operation, and outcome

evaluation of a statewide palliative care consumer and professional information and education program. The PCIAC is integrated into the governing and implementation structure of the educational program.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The PCIAC will typically hold three to five hour public meetings beginning at 10 AM at the HHSC Brown Healty hearing room in Austin. By statute, the PCIAC must meet at least twice each year, although staff anticipate that the council will meet in-person three times per year. The PCIAC has also formed three work groups which may also hold periodic meetings. Work group meetings are likely to be conducted through teleconference.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The PCIAC is a new committee in its first year of operation. The PCIAC plans to develop and manage four deliverables: 1) a biennial policy report submitted to the Executive Commissioner and the standing committees of the Senate and House with primary jurisdiction over health matters; 2) an annual status report summarizing activities and actions of the council submitted to the Executive Commissioner; 3) a plan and ongoing guidance regarding a palliative care consumer and professional information and education program website; and 4) palliative care related educational materials and programs to provide continuing education opportunities for interdisciplinary professionals.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

The PCIAC is currently in its first year. An initial policy report with recommendations for the Legislature and HHSC will be published by October 1, 2016. By statute, the PCIAC must publish such a report by October 1 of each even-numbered year.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

Staff work on behalf of the PCIAC is indistinguishable/fully integrated with the operation of the statewide palliative care information and education program. Program staff manage logistics for all PCIAC full council and work group meetings and facilitate the meetings. Staff also work to produce reports and manage other projects to promote increased availability and access to palliative care. Ultimately, in addition to policy reports, these deliverables will include development and maintenance of a statewide website and coordination of interdisciplinary continuing educational opportunities. Staff perform research and coordinate and prepare policy and data analytics related to the PCIAC's work. Staff coordinate planning discussions via webinar, in-person, or teleconference meetings involving subject matter experts and work group members and meet with stakeholders to discuss and present goals, activities, accomplishments, policy issues, and future directions related to the committee. Staff also coordinate the recruitment of members.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. (In minutes for February meeting; minutes are not yet available for April 15 meeting.)

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meetings are open to the public and opportunity for public comment is provided for each meeting topic and at a designated time during each meeting. The public is also welcome to submit comments in writing to staff supporting the PCIAC. PCIAC meetings will offer opportunities for stakeholders to provide invited presentations and serve as subject matter experts. Notices for PCIAC meetings and other key milestones are distributed to stakeholders via a program distribution list and announced on the program web page. Meetings are also posted to the Texas Register in compliance with Texas Open Meeting Act rules.

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Medical Association, Texas Hospital Association, Texas Association of Health Plans, Texas New Mexico Hospice Organization, Texas Academy of Palliative Medicine, Texas Nurses Association, and Teaching Hospitals of Texas

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

The PCIAC is on track but is still in its initial stages. A more complete and valid assessment will be possible in early 2017.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The committee is necessary for HHSC to get stakeholder direction to guide implementation of H.B. 1874 (84-R).

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

The PCIAC is in its first year and adequate information is not yet available to modify the committee.

Palliative Care Interdisciplinary Advisory Council: Proposed Bylaws

ARTICLE I LEGAL AUTHORITY

The Palliative Care Interdisciplinary Advisory Council (Palliative Care Council or Council) is established in accordance with Texas Health and Safety Code Chapter 118, as adopted by Act of May 23, 2015, 84th Leg., R.S., §2 (H.B. 1874).

ARTICLE II PURPOSE

The Palliative Care Council assesses the availability of patient-centered and family-focused interdisciplinary team based palliative care in Texas for patients and families facing serious illness. The Council works to ensure that relevant, comprehensive, and accurate information and education about palliative care, including complex symptom management, care planning, and coordination needed to address the physical, emotional, social, and spiritual suffering associated with serious illness is available to the public, health care providers, and health care facilities.

ARTICLE III TASKS

The Palliative Care Council performs the following tasks:

1. Consults with and advises HHSC on matters related to the establishment, maintenance, operation, and outcome evaluation of the palliative care consumer and professional information and education program (program) established under Texas Health and Safety Code §118.011;
2. Provides direction to HHSC and program staff on content and governance for the palliative care information website authorized by Texas Health and Safety Code §118.011(b);
3. Studies and makes recommendations to remove barriers to appropriate palliative care services for patients and families facing serious illness in Texas of any age and at any stage of illness;
4. Pursues other deliverables consistent with its purpose as requested by the Executive Commissioner of HHSC (Executive Commissioner) or adopted into the work plan or bylaws of the council.

By October 1st of each even-numbered year, the Council shall submit a written report on its determinations and recommendations to the Executive Commissioner and the standing committees of the Texas Senate and House with primary jurisdiction over health matters.

ARTICLE IV
MEMBERSHIP RULES

The Palliative Care Council is composed of interdisciplinary professional members appointed by the Executive Commissioner as described by Texas Health and Safety Code §118.004 for a term of four years.

ARTICLE V
PRESIDING CHAIR and VICE-CHAIR SELECTION

The Palliative Care Council will elect from its members a Chair and Vice-Chair.

1. The term of office for presiding officers is two years with the Chair serving until December 31 of each odd-numbered year and the vice-chair serving until December 31 of each even-numbered year.
2. No limits are set on the number of terms a member may serve as Chair or Vice-Chair.
3. The Chair and Vice-Chair remain in their position until the Palliative Care Council selects a successor; however, the individual may not remain in office past the individual's membership term.
4. The Chair and Vice-Chair are elected according to the following procedures:
 - a) Members are allowed to nominate themselves or another member;
 - b) Prior to a vote, each nominated member will make a short statement;
 - c) Voting will be confidential: when nominations are closed and a vote is called, each member will write the name of a candidate on a ballot and submit it to staff;
 - d) A candidate with a plurality of votes wins the election;
 - e) In the event of a tie vote, the candidates who tied will be invited to make a brief statement, and a new round of voting involving only those candidates will occur.
5. In the event the Chair and Vice-Chair offices are vacant simultaneously, the election for Chair will precede that for Vice-Chair.

ARTICLE VI
PRESIDING CHAIR and VICE-CHAIR DUTIES

Responsibilities of the Chair include the following:

1. Preside at council meetings;
2. Serve as the council spokesperson or arrange for another member to represent the council before an agency board, legislative committee, or other group as requested and appropriate;
3. Ensure that the council adheres to its charges;
4. Ensure that reports and other deliverables are submitted as required;
5. Confer with HHSC staff in:
 - a) Preparing meeting agendas;
 - b) Planning council activities;
 - c) Establishing meeting dates and calling meetings;
 - d) Establishing workgroups and ad hoc committees;
 - e) Appointing council members to serve on workgroups and ad hoc committees;
6. The Vice-Chair acts as Chair at such time as the Chair is unavailable or unable to serve.

ARTICLE VII
BOARD MEMBER VACANCY AND FILLING A VACANCY

If any member of the Palliative Care Council wishes to resign, the member shall contact, in writing, both the current Chair and the Executive Commissioner requesting the appointment of a successor member. If any member of the Council dies or becomes incapacitated, the Chair shall contact in writing the Executive Commissioner requesting the appointment of a successor member. All council members serve at the pleasure of the HHSC Executive Commissioner.

In the case of a vacancy for any reason, the Executive Commissioner will fill the vacancy in the same manner as the original appointment to serve the unexpired portion of the term of the vacant position.

ARTICLE VIII
OPERATIONS

The Palliative Care Council will observe the following operational procedures:

1. A quorum will be 51% of the members;
2. The Council is authorized to transact official business only when in a legally constituted meeting with a quorum present;
3. The Council is subject to Texas Government Code Chapter 551 (Texas Open Meetings Act);
4. Roberts Rules of Order shall be the basis of parliamentary decisions except where otherwise provided by law, rule, or bylaw;
5. Any action taken by the committee must be approved by a majority vote of the members present once quorum is established, except where provided by other law, rule, or bylaw;
6. Recommendations made to the Legislature, a state agency, or other body are determined by a record vote and require a two-thirds majority of members present once quorum is established.

ARTICLE IX
RESPONSIBILITIES OF MEMBERS

Palliative Care Council members are expected to perform the following tasks:

1. Regularly attend meetings and other scheduled Council activities;
2. Inform HHSC staff promptly if you will be unable to attend a Council meeting or activity;
3. Review agendas and other information sent by HHSC staff to members before the meetings and participate in all discussions at meetings;
4. Abstain from voting or deliberating on issues that would provide monetary or other gain or that present a conflict of interest to the member or an entity with which the member is closely affiliated;
5. Comply with all ethics policies adopted by HHSC or the Texas Ethics Commission;
6. Take the Texas Attorney General's Open Meeting Act and Public Information Act Training within 90 days after the member's first Council meeting and provide a certificate of completion to the HHSC staff contact;
7. Council members may not participate in legislative activity in the name of HHSC or the Council without approval through HHSC's legislative process; however, members are not prohibited from representing themselves or other entities in the legislative process;
8. A Council member should not disclose confidential information acquired through his or her participation on the Council.

ARTICLE X
SUBCOMMITTEES

As the need arises, the Chair may appoint standing or ad hoc workgroups:

1. Members of workgroups are not required to be members of the Council, but a member of the Council must lead the workgroup;
2. Workgroup members who are not members of the Council must be a designated subject matter expert;
3. Workgroups are for the purpose of assisting staff with researching topics and planning for full council meetings and do not vote or take official action.

ARTICLE XI
SUBJECT MATTER EXPERTS

The Palliative Care Council recognizes the value of subject matter experts (SME) to provide information to the Council as it develops recommendations and initiatives to meet its charges. The primary role of a SME is to provide objective, independent information and analysis to be considered by the Council. SME participation will be subject to the request of voting council members and will fall within the following guidelines:

1. A SME may be invited to provide information on specific subjects and topics at the discretion of voting council members, the Chair, and HHSC;
2. An invited SME may be recognized by the work group lead, Vice-Chair, or Council Chair to provide information or analysis during allotted time periods at a specified workgroup or full council meeting;
3. SMEs will participate in questions and answers at the direction of the work group lead, Vice-Chair, or Council Chair;
4. All SMEs will participate and serve at the pleasure of the Council;
5. SMEs do not hold any official capacity on the Council and do not have rights of deliberation or the right to vote on any Council activities or decisions;
6. SMEs should disclose any conflicts of interest they may have prior to providing information to the Council;
7. None of the information or guidance contained in this article shall prevent any individual from participating in or providing comments to the Council as allowed under the Texas Open Meetings Act.

ARTICLE XII
COMPENSATION

A member of the Palliative Care Council is not entitled to any compensation. However, per H.B. 1874 (84 R), a member may receive reimbursement for reasonable transportation costs following state protocols, provided that funding is available.

ARTICLE XIII
ADOPTION AND REVISION TO BYLAWS

By a vote of not less than two-thirds of all voting members, the Palliative Care Council may amend these bylaws.

ARTICLE XIV

The bylaws become effective as of the date they are adopted by the Council.

**The Palliative Care Interdisciplinary Advisory Council
Meeting #1 Minutes
February 12, 2016
10 a.m.**

**University of Texas
Thompson Conference Center
Room 3.102
2405 Robert Dedman Drive
Austin, Texas 78712**

Agenda Item 1: Welcome and introductions

The Palliative Care Interdisciplinary Advisory Council (PCIAC) meeting commenced at 10:00 a.m. Mr. Jimmy Blanton, Health and Human Services Commission (HHSC) welcomed everyone to the meeting.

Agenda Item 2: Opening Statements

Mr. Blanton introduced Ms. Megan White and Ms. Shanece Collins that are HHSC staff working to support the Council. Mr. Blanton noted that all members were in attendance. Table 1 notes Council member attendance.

Table 1: The Palliative Care Interdisciplinary Advisory Council member attendance at the Friday, February 12, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Allmon, Jennifer Carr	X		Jones, Barbara PhD	X	
Botts, DeilaSheun	X		Jones, Margaret	X	
Castillo, James MD	X		Jones, Nathan Jr.	X	
Christensen, Bruce	X		Kean, Mary Beth	X	
Driver, Larry MD	X		Moss, Amy DO	X	
Fine, Robert MD	X		Perez, Erin	X	
Fleener, Erin MD	X		Ragain, Roger Mike MD	X	
Henderson, Hattie MD	X		Scott, Cam	X	
Hurwitz, Craig MD	X		Sevcik, Lenora Carvajal	X	

Yes: Indicates attended the meeting
P: Indicates phone conference call

No: Indicates did not attend the meeting

- Mr. Blanton has worked in Public Health with HHSC and the Department of State Health Services (DSHS) for 20 years, working primarily in analytics and data. Four years ago he was named Director of the Texas Institute of Healthcare Quality and Efficiency and worked with a board similar to the PCIAC to create recommendations for quality and efficiency for healthcare. Mr. Blanton then asked each member to introduce themselves.
- Dr. Erin Fleener is a medical oncologist in a busy private practice in Bryan/College Station. She sat on the board for the local non-profit Hospice Brazos Valley and was involved in advocating for House Bill (H.B.) 1874, 84th Legislature, Regular Session, the legislation that created the PCIAC.
- Mr. Cam Scott is the Senior Director for Texas Government Relations with the American Cancer Society Cancer Action Network which championed this work during the last legislative session. Mr. Scott referenced the document *America's Care of Serious Illness 2015 State-by-State Report Card on Access to Palliative Care in our*

Nation's Hospitals provided to members in the packet noting that Texas is leading the way in getting to the forefront on this issue.

- Ms. Patty Moore, Ph.D., is the Director of the Health Promotion and Chronic Disease Prevention Section with DSHS. Ms. Moore has trained as a health service researcher and has personal experience with palliative care for a family member.
- Ms. Margaret Jones is a board certified hospital chaplain for Christus Santa Rosa Hospital in New Braunfels.
- Ms. Lenora Sevcik helped develop the palliative care program at Midland Memorial Hospital in Midland. She has relocated to Corpus Christi to work with the Christus Health System and is the palliative care nurse for her father.
- Ms. Karen Hardwick, Ph.D., is the Coordinator for Specialized Therapies for the Department of Aging and Disability Services (DADS). Her specialty is occupational therapy, and she has worked with individuals with developmental disabilities (IDD) for over 40 years.
- Ms. DeiLaSheun Botts is a registered nurse (RN) by training and has worked with every population throughout the span of life -- from neonates to elderly patients. She currently works as the Health Services Director for United Healthcare Community Plan of Texas with the Medicaid population to educate individuals about their health choices.
- Dr. Bob Fine has completed boards in internal medicine, geriatrics, and palliative medicine. He is the founder and Clinical Director of both Clinical Ethics and Supportive & Palliative Care at Baylor Scott and White Health, several hospitals of which have been recognized for excellence in palliative care by the Joint Commission and/or the American Hospital Association. He has served on the ethics committee of the AAHPM, the 2014 National Quality Forum EOL Steering Committee, and the Editorial Board of the Journal of Pain and Symptom Management.
- Ms. Erin Perez, a nurse practitioner (NP), does palliative care for the geriatric population in a consultative practice with Baptist Health System in San Antonio. She testified for H.B. 1874 and noted that Texas is far behind states on the West and East Coast, but Texas can look at ways to speed up the process and provide excellent care as well as be a good steward of funds.
- Dr. Mike Ragain, board certified in palliative care, is the chief medical officer of UMC, the teaching hospital for the Texas Tech School of Medicine in Lubbock. He authored a grant and received funding to start a program on palliative care for medical students and help develop a palliative care fellowship that graduates two palliative care fellows each year.
- Dr. Hattie Henderson is a trained family physician and an advocate for patients working mostly with the geriatric population. Patient education is important to help families speak with providers for a better quality of life.
- Mr. Bruce Christensen is a physician assistant and the president of the Texas Academy of Physician Assistants. He works at the Cancer Therapy and Research Center at the University of Texas Health Science Center in San Antonio.

- Ms. Mary Beth Keen is a clinical nurse specialist and an advanced practice nurse who began her work in palliative care in Canada in 1993. She has worked with Dr. Fine as well as Dr. Driver on the Texas Pain and Advocacy Network, and for Seton collaborating with Dr. Hurwitz. Her personal experience with palliative care in Florida involved the death of her mother and motivates her to improve care for others.
- Dr. Larry Driver is a Professor in the Department of Pain Medicine and a Professor of Clinical Ethics at the University of Texas MD Anderson Cancer Center in Houston. At a very young age, he watched his grandmother provide care for his great grandmother, then watched his mother provide care for his grandmother. In a psychology class on death and dying in college, he learned from visiting professor, Elizabeth Kübler-Ross, a pioneer in the field near-death studies and in the movement to promote the availability of hospice care. He trained in anesthesiology in medical school with a desire to ease pain for patients.
- Dr. James Castillo is a palliative care physician in the Rio Grande Valley. As part of the inaugural residency class of palliative care at the University of Texas San Antonio, he brought palliative care to the Valley to enact change. He became a hospitalist and helped build the palliative care program at Valley Baptist Medical Center in Harlingen. His current ventures involve working with Aspire Healthcare to expand outside of the hospital walls to establish home-based palliative care which has resulted in a 65 percent reduction in hospital inpatient admission.
- Mr. Nat Jones is a pharmacist with family experience with cancer. He owned and ran a compounding pharmacy for 20 years as compounding is something that meets those unique needs of patients and their family members when patients are not treated in facilities.
- Dr. Amy Moss is a geriatrician internist representing Kindred Healthcare. She is the national medical director for their Hospice Division and also serves as the medical director for a palliative care service line delivered in the NICU through to the other end of the spectrum as a large consult service.
- Ms. Jennifer Carr Allmon is the Associate Director of the Texas Catholic Conference of Bishops which serves as the Bishops' public policy voice. She completed certification as a bioethicist through the National Catholic Ethics Center with focus on informed-consent, autonomy, and a balance of patient and provider rights.
- Dr. Rajendra Parikh is the Medical Director of Texas Medicaid and is an ex-officio member. He commented to the importance of broad representations of backgrounds because of the interaction between physicians and their patients for decision-making.
- Dr. Jim Rogers is a board certified child and adolescent psychiatrist serving as the medical director for the Texas Department of Family and Protective Services (DFPS). Dr. Rogers has limited family experience with palliative care and what had him face death most poignantly was the diagnosis of Leukemia for his eldest child in 1984. They did not have palliative care and she was in treatment for two and a half years; today she is a nurse. In foster care, many children are seriously medically ill and would benefit from palliative care.
- Ms. Barbara Jones, Ph.D. is the Assistant Dean for Health Affairs and a professor at the University of Texas in Austin. She began her career as a pediatric oncologist social worker doing pediatric palliative care. Currently, her work is not clinical but

involves conducting research for how to improve care for patients. She also provided testimony for H.B. 1874.

- Dr. Craig Hurwitz has worked as a pediatric oncologist for the past 30 years. He is the director of the Pain and Palliative Medicine Program at Dell Children's Medical Center.

Agenda Item 3: Appointment Terms

Mr. Blanton announced that the standard term is four years but because this is the first term and the Council will be staggering appointment terms, some Council members will have an initial term of two-years. Terms will expire on December 31 of even-numbered years.

Appointment terms were as follows:

Dr. Castillo - 2 year
Dr. Driver - 4 year
Dr. Fine - 2 year
Dr. Fleener - 2 year
Dr. Hurwitz - 4 year
Dr. Moss - 2 year
Dr. Ragain - 4 year
Ms. Kean - 2 year
Ms. Perez - 2 year
Mr. Christensen - 4 year
Ms. Carvajal Sevcik - 4 year
Ms. B. Jones - 4 year
Mr. Jones - 4 year
Ms. M. Jones - 2 year
Ms. Carr Allmon - 2 year
Ms. Botts - 2 year
Dr. Henderson - 4 year
Mr. Scott - 4 year

Action Item:

Mr. Blanton asked that any Council member that drew a four-year term but desired a two-year term please notify staff.

* Following the meeting, Ms. Perez and Ms. Sevcik exchanged appointment terms.

Agenda Item 6: Election of Presiding Officer and Assistant Presiding Officer

Mr. Blanton referenced the PowerPoint and described the process for electing a chair and vice chair and asked for nominations from Council members.

Motion:

Members stated no objections to the process for electing a chair. Ms. Perez made a motion to accept the process. Ms. Botts seconded the motion. With no nays and no abstentions, the motion passed unanimously by voice vote.

Mr. Blanton called for nominations.

- Dr. Driver self-nominated for the inaugural chair of the PCIAC. Stating his support from MD Anderson and the groups there, as well as support of fellow doctors in the Texas Medical Association (TMA) to help move this effort forward.

- Ms. Perez self-nominated stating her support and backing by the Texas Nurse Practitioners, the University of Texas Medical Branch, and the Baptist Health System allowing her to serve on their behalf.
- Dr. Hurwitz nominated Dr. Barbara Jones and she accepted the nomination.
- Dr. Ragain self-nominated, noting his experience leading the Statewide Health Coordinating Council and his willingness to serve, if chosen.

Public Comment:

Dr. Dennis Pacl, in private practice in Austin, asked that the chair or vice-chair have a strong background in public policy. He noted the broad clinical expertise of members and the smaller amount of public policy experts.

Motion:

Mr. Scott made a motion to conduct the election votes separately: one for chair and a second for vice-chair. Dr. Fleener seconded the motion. With no nays and no abstentions, the motion passed unanimously by voice vote.

Mr. Blanton noted that this process will become part of the bylaws and that under current draft rule, the presiding officer term will be a two-year term with the chair term ending in an even year and the vice-chair term ending in an odd-numbered year.

Mr. Blanton restated that Dr. Driver, Ms. Perez, Dr. Barbara Jones, and Dr. Ragain accepted nominations for chair. Members voted by paper ballots. Mr. Blanton announced that Dr. Driver was elected chair by majority vote.

Mr. Blanton called for nominations for vice-chair. Hearing none, Mr. Blanton restated the nominees for chair as Ms. Perez, Dr. Barbara Jones, and Dr. Ragain. Council members voted by paper ballot and Dr. Barbara Jones was elected vice-chair of the PCIAC.

Action Item:

- Mr. Blanton will work with the Facilitation Services Office to ensure that the bylaws reflect the desires of the Council in regards to election of officers.

The Council adjourned for lunch at 11:58 a.m. and reconvened at 12:34 p.m. with Dr. Driver presiding.

Agenda Item 4: Background Presentations

i. House Bill 1874 and Legislative Charges

Mr. Blanton referenced the PowerPoint and the documents entitled *H.B. No. 1874*, and *Rule 351.8XX The Palliative Care Interdisciplinary Advisory Council*.

Highlights of the presentation included:

- H.B. 1874 charged the Commission to establish an advisory council to assess the availability of patient-centered and family-focused palliative care in Texas.
- Many members mentioned that palliative care is not just for end of life care, but for patients at all ages and all stages of a serious illness.
- The Council will have four meetings this year to complete work for the policy report and to launch the education program prior to the upcoming legislative session.

ii. Rules and Bylaws

Mr. Blanton referenced the PowerPoint and the documents entitled *H.B. No. 1874, Rule 351.8XX The Palliative Care Interdisciplinary Advisory Council*, and the rule document edited by Dr. Fine provided in the member packet. Mr. Blanton noted that HHSC is in the process of doing the draft rules and wanted the ability to receive feedback from stakeholders and committees.

- Staff will be filing two reports for the Council. One will be filed with the HHSC Executive Commissioner that will include the meeting dates, attendance records, and a description of items the Council worked on.
- The second report will be a work product to provide information for the Executive Commissioner and the Legislature and provide recommendations consistent with the purpose of the Council.

Members discussed the edits to the draft rule provided by Dr. Fine.

Motion:

Dr. Fine made a motion to accept the edits to the draft rule, submitted by the Council. Dr. Barbara Jones seconded the motion.

Additional discussion included:

- Dr. Barbara Jones noted that this is a pretty significant addition to what the legislation states in definition of the Council and there may be dispute with the general public. However, part of the charge of the Council is defining palliative care.
- Dr. Parikh, as a non-voting member, added that the term alignment of physical, emotional, and spiritual pain in the same direction may be contradictory. The reduction of physical pain may not create reduction of spiritual pain, based on upbringing.
- Make a change from "address" spiritual pain to "lessen" spiritual pain. It may not be possible to lessen spiritual pain or spiritual turmoil but may address it.
- The domain of care calls for "spiritual" and making a change to "holistic" may be connoted in a variety of ways.

Dr. Fine restated the sentence to read: "The Council works to ensure that relevant, comprehensive, and accurate information and education about palliative care including complex symptom management, care planning coordination needed to address the physical, emotional, social, and spiritual suffering associated with serious illness is available to the public, health care providers, and health care facilities."

Motion:

- Dr. Driver called for a vote of the language that Dr. Fine restated to the Council. With no nays and no abstentions, the motion passed unanimously by voice vote.

Mr. Blanton restated discussion making a change to align the terms of the Chair with the legislative session.

Motion:

Dr. Castillo made a motion to align the term of the presiding officer with the legislative session. Dr. Hurwitz seconded the motion. With no nays and no abstentions, the motion passed unanimously by voice vote.

Mr. Blanton restated discussion that term of office would expire on the odd numbered years instead of even-numbered years, to allow the chair to serve a full four years to ensure completion of Council deliverables.

Motion:

Dr. Fleener made a motion to change the term of office to expire on the odd-numbered years instead of even-numbered years. Dr. Castillo seconded the motion. With no nays and no abstentions, the motion passed unanimously by voice vote.

Action Item:

- Mr. Blanton will ensure that the recommendations made by Dr. Fine are submitted to the staff that are reviewing the rules.

iii. Background from other State focused Initiatives

Ms. White stated that a SharePoint site will be set up to share information among staff and Council members. Ms. White noted that it is important to continue looking at the work other states are doing and thanked Ms. Perez and everyone that submitted materials.

Action Item:

- Mr. Blanton will put in a request for SharePoint and will get accounts established for members.

Agenda Item 5: Council Discussion on Background Presentations

Mr. Blanton referenced the PowerPoint to initiate discussion for how to divide the work into workgroups.

Agenda Item 7: Council Discussion on Initial Deliverables and Work Plan**i. Timelines**

Mr. Blanton reviewed the PowerPoint and the documents entitled *PCIAC Timeline (Proposed)* and the graph timeline also entitled *PCIAC Timeline (proposed)*. Mr. Blanton stated that in order to meet the October 1, 2016 deadline, it will be necessary to have the report completed by September 1, 2016. At the full Council meeting in July, staff will have a complete draft of the recommendation report for the Council to consider and ensure that the recommendations are approved with the precise language and conditions the Council wants included in the narrative.

ii. Guidelines for Recommendations

Mr. Blanton stated that the Council is not making the policy but providing a collective voice to policymakers.

iii. Definition of Palliative Care

Members noted the importance of looking at palliative care for all ages.

iv. Focus Areas

Mr. Blanton reviewed the PowerPoint and noted the key focus areas including barriers and access to care; policies, practices, and protocols; and a third area to include establishment of an information and education program.

v. Data/Analytical Needs

Mr. Blanton noted that the first focus area of 'barriers and access of care' would require collection of data and would be a larger volume of work for that workgroup.

vi. Potential Work Groups

Mr. Blanton referenced the documents entitled *PCIAC Work Groups (Proposed)*. Staff will hold workgroup calls to compile the recommendations before the next full Council meeting scheduled in April when recommendations will be voted on. Some specific items that need guidance include access to care and data.

vii. Future Meetings

Mr. Blanton noted that part of the Council's charge is to identify what resources or expertise is needed for the Council to utilize. He further noted that regarding the budget, funds may be rolled forward to plan some expenditures for the second year of this biennium.

Dr. Driver commented that if the Council produces excellent materials, lawmakers may provide additional funding to enable them to reach more people. Dr. Driver also stated that grant funding may be considered in the future.

Members will identify their interests in order to select a workgroup on which to participate. As chair, Dr. Driver may assign members to workgroups or they may select them, as long as a quorum is not reached.

Public Comment:

Dr. Pacl provided a written comment.

"Under workgroup 3, the focus seems to be on education resources. It would be essential to recognize the limited impact that information and training in Palliative Care will have limited direct benefit for patients and their informal caregivers. Given the triple aim for optimizing health care systems, a major determinant of patient centeredness, population health, and cost reduction - involves the social determinants of health. With that in mind, it seems to me as an individual devoted to patient safety and the experience of consumers in health care settings, the advisory council would be remiss if research and mapping of consumer experience across settings, and review of effective support programs and training models for informal caregivers, was not a specific charge of work group 3, and/or work group 2. This patient and caregiver advocacy, for specific consideration of the consumer stakeholder landscape in this council's work, would go a long way to move the CAPC grade and changing the culture of clinical practice through empowered and trained consumers."

Motion:

A motion was made and seconded to accept the proposed workgroups, as recommended. With no nays and no abstentions, the motion passed unanimously by voice vote. The adopted workgroups included:

- 1) Barriers and Access to Care;
- 2) Policies, Practices, and Protocols; and
- 3) Information and Education.

Action Item:

- Mr. Blanton will include information about the budget in the next meeting.
- Mr. Blanton will send an email to members to rank their interests for the three workgroups.

Agenda Item 8: Public Comment

No public comment was heard.

Agenda Item 9: Action items for staff or member follow-up

- Mr. Blanton will send out an email to the membership asking for responses for the three workgroups by Tuesday.
- Mr. Blanton will also ask for leadership to get those as well, then start scheduling calls.
- Mr. Blanton will include the Council's comments on the rules with the draft and as soon as the meeting is concluded, will get the draft changes submitted by deadline at the end of the day.
- Mr. Blanton will provide the email address for Dr. Driver at member's request.
- The Facilitation Services Office will provide the draft meeting minutes to Mr. Blanton for review by the Council to make changes or corrections, then approve at the next meeting.

Mr. Blanton referred to the document *Travel Reimbursement Guidelines: Palliative Care Interdisciplinary Advisory Council* provided in the member packet and stated that authorized travel may be reimbursed according to the guidelines.

Agenda Item 10: Adjourn

Dr. Driver adjourned the meeting at 2:03 p.m.

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:

Number of Members:

Committee Status (Ongoing or Inactive): Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: **Date to Be Abolished:**

Budget Strategy (Strategies) (e.g. 1-2-4): **Strategy Title (e.g. Occupational Licensing):**

Budget Strategy (Strategies): **Strategy Title:**

[State / Federal Authority](#)
[State Authority](#)
[State Authority](#)

[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Select Type	Identify Specific Citation
Statute	Sec 241.187, Health & safety code

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$6,000	\$8,000	\$30,000
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$6,000	\$8,000	\$30,000

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.7	0.7	0.7
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0

Expenses / MOFs Difference:

Meetings Per Fiscal Year

Committee Description: Purpose: Develops and recommends a process and criteria for designating levels of neonatal and maternal care, respectively, and to make recommendations related to improving neonatal and maternal outcomes. Recommendations for Neonatal levels of care criteria have been made and new rule is close to being adopted. PAC is now working on Maternal levels of care criteria.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Hospitals currently self designate their capabilities to care for moms and babies. This committee is assisting the state in defining criteria based on national standards that can be used to ensure hospitals are designated to their actual capabilities.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

Perinatal Advisory Council Guiding Principles

ARTICLE I **LEGAL AUTHORITY**

- The Perinatal Advisory Council (PAC) is authorized and governed by H.B. 15, 83rd Legislature and H.B. 3433, 84th Legislature.
- The Perinatal Advisory Council is abolished on September 1, 2025.

ARTICLE II **PURPOSE**

The Perinatal Advisory Council shall advise and make recommendations to the Texas Health & Human Services Commission (“HHSC”) and the Texas Department State Health Services (“DSHS”) on the development of a process for the designation and updates of levels of neonatal and maternal care at hospitals in Texas.

The council shall:

1. Develop and recommend criteria for designating levels of neonatal and maternity care, including specifying the minimum requirements to qualify for each level designation
2. Develop and recommends a process for the assignment of level of care to a hospital for neonatal and maternal care
3. Make recommendations for the division of the state into neonatal and maternity care regions
4. Examine utilization trends relating to neonatal and maternal care
5. Make recommendations related to improving neonatal and maternal outcomes
6. Make recommendations for confidential reporting requirements
7. Assists in the designation of the centers of excellence for fetal diagnosis and therapy as required by Texas Health and Safety Code 32.072
8. Performs other tasks consistent with its purpose as requested by the Executive Commissioner.

By September 1, 2016, the PAC shall submit a report to HHSC, DSHS and the Executive Commissioner on its determinations and recommendations designating levels of neonatal and maternal care and other recommendations.

Perinatal Advisory Council

Guiding Principles

ARTICLE III

MEMBERSHIP

1. The Perinatal Advisory Council consists of 19 members
 - a. Each member is appointed by the Executive Commissioner
 - b. Membership is allocated consistent with Texas Health & Safety Code 241.187.
2. Members of the PAC serve staggered three-year terms, with the terms of six members expiring each September 1st.
3. A members may be reappointed

ARTICLE IV

PRESIDING CHAIR and VICE CHAIR

The Executive Commissioner of HHSC appoints the Chair of the PAC. The Chair will appoint a Vice Chair to serve in the Chair's absence. The role of the Chair is to:

- A. Provide democratic leadership;
- B. Promote and maintain a participatory environment;
- C. Ensure the PAC adheres to its charge; and
- D. Confer with HHSC and DSHS staff to acquire the support needed for operations.

Beginning September 1, 2017 the PAC will select a presiding officer from among its members. Unless reelected, the presiding officer serves a term of one year.

Perinatal Advisory Council

Guiding Principles

ARTICLE V

BOARD MEMBER REMOVAL AND FILLING A VACANCY

If any member of the Perinatal Advisory Council wishes to resign, the member shall contact, in writing, both the current Chair and the HHSC Executive Commissioner requesting the appointment of a successor member. If any member of the Perinatal Advisory Council dies or becomes incapacitated, the Chair shall contact in writing the HHSC Executive Commissioner requesting the appointment of a successor member. For the 6-9 meeting to be scheduled and held between January 2016 thru August 31, 2017, if any member misses three or more meetings in a 12 month calendar year, with or without notice to the designated HHSC staff, the member shall be removed from the Perinatal Advisory Council and the Chair shall send written notice to the HHSC Executive Commissioner requesting the appointment of a successor member.

ARTICLE VI

MEETING OPERATIONS

- A quorum will be 51% of the members.
- The PAC is subject to Texas Government Code Chapter 551 (the Texas Open Meetings Act).
- The PAC uses Robert's Rules of Order as a guide in conducting its business.
- The passage of any measure other than the PAC's Guiding Principles requires a majority of those voting.
- The passage of the PAC's Guiding Principles and any amendment to the adopted guiding principles requires a two-thirds majority of the membership and is determined by a record vote
- A record vote on any measure may be requested through a simple motion and second

Perinatal Advisory Council

Guiding Principles

ARTICLE VII

RESPONSIBILITIES OF MEMBERS

PAC members are expected to perform the following tasks:

- A. Attend all meetings;
- B. Review agendas and other information sent by HHSC staff to members before the meetings and participate in all discussions at meetings;
- C. Abstain from voting on issues that would provide monetary or other gain or that present a conflict of interest to the member or an individual or business partner or entity with which the member is closely affiliated;
- D. Comply with all ethics policies adopted by HHSC or the Texas Ethics Commission.
- E. Take the Texas Attorney General's Open Meeting Act and Public Information Act Training within 90 days of first PAC meeting and provide a certificate of completion to the HHSC staff contact.

ARTICLE XIII

SUBCOMMITTEES AND WORKGROUPS

As the need arises, the Chair may appoint subcommittees and workgroups. Members of subcommittees are not required to be members of the PAC, but a member of the PAC must be the chair of any such subcommittee.

ARTICLE XIV

COMPENSATION

A member of the Perinatal Advisory Council is not entitled to any compensation. However, H. B 15 does have a provision to provide reimbursement for normal and reasonable travel expenses based on state guidelines and provided such resources are available.

Perinatal Advisory Council Guiding Principles

ARTICLE XVI

ADOPTION AND REVISION TO GUIDING PRINCIPLES

- A. By a vote of not less than two-thirds of the members, the PAC may recommend alterations or amendments of the rules to the HHSC staff.
- B. Whenever any alterations or amendments are made to the rules, the new rules will be provided to each member of the PAC.

ARTICLE XVII

The Guiding Principles will become effective as of the date they are adopted by the PAC and are applicable until September 1, 2017, when the terms expire for the first six members as described in H.B.15.

After September 1, 2017, a new document of guiding principles will be initiated for the term of one year to cover new members rotated into the Perinatal Advisory Council.

**Perinatal Advisory Council
Meeting #13 Meeting Minutes
Tuesday, November 17, 2015
10:30 a.m. to 3:00 p.m.**

**Brown-Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, TX 78751**

Agenda Item 1: Call to Order

The Perinatal Advisory Council (PAC) meeting commenced at 10:30 a.m. with Dr. Eugene Toy serving as chair. Dr. Toy welcomed everyone to the meeting.

Agenda Item 2: Roll Call and Introduction of New Members

Mr. David Williams called the roll and noted that a quorum was present for the meeting.

Ms. Cassandra Marx announced that the meeting was being conducted in accordance with the Texas Open Meetings Act.

Table 1: The Perinatal Advisory Council member attendance at the Tuesday, November 17, 2015 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Blanco, Cynthia MD	X		Perez, Annette	X	
Briggs, Emily MD	X		Rivers, Sandra	X	
Cho, Frank MD	X		Saade, George MD		X
Greer, Barbara	X		Speer, Michael MD*		X
Guillory, Charleta MD		X	Stanley, Michael MD	X	
Harrison, Allen	X		Stelly, Christina		X
Harvey, John MD	X		Toy, Eugene MD	X	
Hollier, Lisa MD	X		Woerner, Steve	X	
Molina, Alyssa MD		X	Xenakis, Elly MD	X	
Patel, Sanjay MD	X				

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

* Dr. Speer serves in an ex-officio capacity

Table 2: The Perinatal Advisory Council staff attendance at the Tuesday, November 17, 2015 meeting.

STAFF NAME	YES	NO	STAFF NAME	YES	NO
Ferrara, Matt	X		Collins, Shanece	X	
Guerrero, Jane	X		Stevenson, Elizabeth	X	
Lynch, David	X		Williams, David	X	

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 3: Approval of the Minutes (September 22, 2015)

Dr. Toy called for a motion to approve the minutes of the September 22, 2015 meeting. Dr. John Harvey motioned to approve the minutes of the September 22, 2015 meeting. Dr. Lisa Hollier seconded the motion. The Council members unanimously approved the minutes by voice vote with no nays and no abstentions.

Dr. Toy announced the new members to the council. Dr. Cynthia Blanco, Neonatologist, University of Texas San Antonio, has served on a PAC subcommittee and will be replacing

Dr. Honrubio, who resigned his position earlier in the year due to increasing clinical demands. Dr. Toy added that House Bill (H.B.) 3433 stipulated that two rural members be placed on the council and he welcomed Ms. Saundra Rivers and Dr. Alyssa Molina to the Council. Ms. Rivers, Nurse Manager of Obstetrics, Rolling Plains Memorial Hospital in Sweetwater, Texas, is actively engaged in the rural subcommittee. Dr. Molina is from Eagle Lake and was not able to attend the meeting.

Agenda Item 4: Status of Draft Rules Proposed for Neonatal Levels of Care

Ms. Jane Guerrero, DSHS, provided an update on the draft Neonatal Levels of Care (LOC) rules and noted that the proposed rules are anticipated to be published in the Texas Register on Friday, November 20th for a 30-day open public comment period.

Public comments are submitted electronically and will go to Ms. Guerrero. The PAC will provide a response as part of the public comment. Dr. Toy encouraged participants to take a look at the website and think about making comments to ensure the rules are done in a way that minimizes unintended consequences.

Dr. Toy went through the document *Recommended Changes to TX Neonatal Design Rules* that was provided to Council members.

Highlights of member discussion were as follows:

- Concern was expressed about potential legal risks and reimbursement for a hospital being designated as a level I pending a site visit when providing Levels II, III, or IV care.
- Ms. Guerrero reiterated that the rule states that reimbursement is not tied to the designation, and hospitals have to be able to provide a certain level of care before being verified at that level.
- Dr. Toy recommended adding the phrase "until the site survey is completed." Facilities will temporarily receive a Level I designation until the site survey is done. As written, there is no end-date and it may be interpreted differently.
- Dr. Toy further recommended revisiting the topic of Level I designation at the next meeting. It is not meant to be penalizing or prohibitive to facilities.
- It was recommended to add language to "ensure appropriate follow-up for at risk infants" born at any Level (I-IV).
- In regards to transfers for surgery, recommended adding phrasing for timeliness rather than geography in that transfer, as timeliness is more enforceable.
- Dr. Harvey recommended changing "higher level designated" to an "appropriate level facility."
- It was recommended to add the word "complicated" to "invasive procedures" when neonatal surgery or complicated invasive procedures are required. Simple invasive procedures such as chest tubes do not need an anesthesiologist.
- Dr. Toy summarized discussion by stating that for the safety of the infant, non-emergent surgeries should not be done at Level I or Level II facilities, and that the concerns of the Council have been heard by Ms. Guerrero and Ms. Stevenson.
- It was recommended to delete "on-site" for all personnel trained in imaging with the exception of x-ray equipment. X-ray technicians need to be both available and on-site. The decision to require ultrasound technicians to also be available and on-site is under consideration.
- It was recommended that inclusion of physical therapists along with occupational and/or speech language pathologists with neonatal and infant experience should be added to manage feeding and/or swallowing disorders.
- It was recommended to strike out "and/or Perinatal care" to ensure the educator RN has strong neonatal and neonatal intensive care (NICU) experience, not just perinatal or obstetrical experience for Level III and IV facilities. A good nurse may

not make a good educator, so having an educator with critical thinking skills and experience is essential.

- Members discussed requiring an anesthesiologist with pediatric experience at Levels I-IV. There was agreement that anesthesiologists at a Level IV facility need to be pediatric anesthesiologists.
- It was recommended that facilities must ensure the timely evaluation and treatment of retinopathy of prematurity onsite including documented policy for monitoring, treatment, and follow-up. At a level IV, it was clarified that a specialist with expertise with neonatal retinal disorders should be available to evaluate and treat ROP.
- Members noted that rules should ensure that survey team members are practicing at the same or higher level as what they are surveying.

Motion:

Dr. Toy asked if everyone agreed to send a letter to the state outlining the recommendations as noted on the document and in discussion today. With no nays, and no abstentions, the Council members unanimously agreed by a show of hands to send a letter to the state with the discussed recommendations, pending an email draft to members first.

Agenda Item 5: Planning Subcommittee Report on House Bill 2131 Subcommittee Requirements

Dr. Toy deferred to Dr. Briggs, PAC Vice-Chair, to lead discussion on this agenda item. Dr. Briggs referred to the report drafted by Dr. Cho regarding the composition of the H.B. 2131 Centers of Excellence subcommittee that the PAC will recommend to the state for consideration.

Dr. Briggs asked members to keep in mind two items for consideration and discussion following Dr. Cho's report: 1) the number and credentials of members of the subcommittee, and 2) whether this designation will require the neonatal levels of care (LOC) to be determined first.

Dr. Cho held three conference calls involving four members of the PAC (Dr. Cho, Ms. Stelly, Dr. Saade, and Mr. Woerner), three stakeholders from the Fetal Centers, two Maternal-Fetal Medicine (MFM) specialists (Dr. Patricia Santiago and Dr. Ken Moise), and a pediatric surgeon, Dr. Oluynka Olutoye. He referenced the handout *PAC Subcommittee on HB2131 November 17, 2015 report* and six North American Fetal Therapy Network (NAFNET) articles that were used as resources.

Highlights from member discussion include:

- Consideration of the timeframe on LOC designation for neonatal standards (2018) and maternity standards (2020). The PAC would like the Fetal Centers of Excellence (FCOE) standards developed in parallel with maternity standards.
- The process should allow for ample consideration of all impact and opportunity for input.
- At least a minimum of The American Congress of Obstetricians and Gynecologists (ACOG) Level III maternity standards should be part of the standards.
- The FCOE Subcommittee should further discuss LOC Level III neonatal centers with surgery and/or a Level IV.
- The "spirit of the bill" refers to the highest level of fetal therapy capability, including further diagnostic evaluation and work-up of fetal conditions, thus it is being defined here as centers that are actively doing fetal surgery.

- Dr. Cho clarified a point addressed by Dr. Hollier regarding the wording under Subgroup B, Consultant Group 2. An ethicist with experience in obstetrics and/or neonatal experience in private practice *or* an academic setting.
- It was noted that the H.B. 2131 FCOE subcommittee needs to keep in mind that there should be a data-driven metric around this designation, instead of a capability-driven metric, because this resulted from patients seeking out-of-state treatment and the resulting outcomes were not as good (as noted during public comment at the last meeting).
- Dr. Cho noted that although it is not part of the recommendations, the subcommittee felt that the H.B. 2131 FCOE subcommittee should define complex procedures and determine if it would include the exit procedures.
- Dr. Toy noted that the FCOE subcommittee should consist of a group smaller than 15 due to the impracticality of setting up working times for a group that large, and recommended having no limit on the number of consultants. He recommended having an odd number, and having a nurse and hospital administrator as part of the core group, with the hospital administrator not affiliated with one of these facilities.

Public Comment:

- Dr. Rashmin Savani, Dallas, commended the deliberation of the PAC subcommittee. Exclusion of complex procedures such as exit procedures that necessarily involve the maternal and fetal care at the end of a very difficult and anticipated birth, and requiring multiple sub-specialty involvement and the exclusion of these would suggest anyone can do these exit procedures. He suggested including these exit procedures as part of the Centers of Fetal Excellence. Building the foundation that Dr. Toy portrayed, and allowing for future potential procedures that are on the horizon, will make a strong foundation.
- Dr. Patrick Ramsey, San Antonio, commended the Council and subcommittee and their work on this. The real 'Spirit of the Bill' should be multi-disciplinary care for the complex fetal cases that fall short of surgery because surgery represents such a limited number of cases. There is a need to look at the big picture, multi-disciplinary care, those that provide the best, integrative care, rather than who can or cannot do surgery. He also encouraged considering input from pediatric cardiology, which can diagnose fetal cardiac abnormalities better than fetal MRI.

Further highlights from member discussion include:

- Dr. Cho noted that if it were to be a reduction in the number of members, that a multi-disciplinary subcommittee is important, having MFM specialists and surgeons is very important, leaving the number of consultants open is a good suggestion, and including members from community nursing, as well as hospital administrators. As orders of importance, having MFMs that practice and do diagnosis on a daily basis, then a balance from an academic and private setting, and secondly, on the surgeon side, discuss most common fetal surgery, having those that diagnose and practice on a daily basis such as a general pediatric surgeon for neonates, and a multi-disciplinary approach for that perspective. Consulting may be a way to pare that down.
- Mr. Steve Woerner noted this deals with new science and will change over time, but the designation will be forever. Having people with a longer-perspective of what the surgery will be ten years from now, and at multiple sites rather than just routine sites, should be represented on a panel.
- Dr. Briggs summarized that a smaller, pared down group with multiple consultants would be beneficial. Having a nurse, a hospital administrator, and as Dr. Cho and the PAC subcommittee recommended, include pediatric surgeons and MFM specialists, with an equal number from academic institutions and private practice to keep a balance.

- Dr. Stanley questioned whether it would be appropriate for the PAC to go to the Legislator that introduced this bill and make recommendations on the fixes that need introduced, to possibly align the timeline, and to change the name from the Centers of Fetal Excellence to Fetal Surgery. This will be up to the subcommittee to discuss.
- Dr. Toy responded that Dr. Cho's subcommittee met three times and made good progress, but it will take time to develop standards that can be translated into rules. If the PAC feels as though this timeline would be harmful and have reasons why, the PAC can make recommendations in that regard.

Public Comment:

- Dr. Savani stated that as the Council is formulating the way the motion is going to read, he re-emphasized Mr. Woerner's comments that it is not just about capabilities but about outcomes. The recommendation may include data-driven metrics to be included within the purview of the subcommittee being formed. This will also address the dilution of care where there may be 2 centers located 100 yards away from each other.

Agenda Item 6: Lunch

The Council recessed for lunch at 12:08 p.m. and reconvened 1:01 p.m.

Agenda Item 5: Planning Subcommittee Report on House Bill 2131 Subcommittee Requirements (continued)

Dr. Briggs resumed with a motion, based on the committee's discussion regarding the composition of the H.B. 2131 Centers of Excellence subcommittee that the PAC will recommend to the state for consideration.

Motion 1:

Dr. Cho made a motion that the H.B. 2131 Subcommittee should consist of two groups with a total of nine members:

- Core group consisting of seven members:
 - Group 1 Maternal Fetal Medicine (MFM): one person from a fetal therapy center, one person from an academic institution that focuses on fetal diagnosis, and two from private practice or community-based Maternal Fetal Medicine, for a total of four, and
 - Group 2 Pediatric Surgeons for the fetus and neonate: one person from a fetal center in an academic institution, one person from a non-fetal therapy center (could be a pediatric neurosurgeon or pediatric surgical subspecialist with experience in an academic or private setting), and one pediatric surgeon with experience in neonatal surgery, for a total of three.
- Consultant Group consisting of two members:
 - One nurse with experience in obstetrical or neonatal in a Level III or Level IV, and one hospital administrator.

Dr. Harvey seconded the motion. With no nays, and no abstentions, the Council members unanimously approved the motion by a show of hands.

Motion 2:

Dr. Briggs noted that the second motion is regarding the timeline and as PAC discussion circled around paralleling the maternity levels of care designation, the motion is to have the timeline mirror that with an ending point in September 2020. Mr. Woerner seconded the motion. With no nays, and no abstentions, the Council members unanimously approved the motion by a show of hands.

Agenda Item 7: Neonatal Intensive Care Unit Utilization Study

Mr. Matt Ferrara, Health Policy and Clinical Services, HHSC, thanked the PAC for its devotion, time, and dedication. He referenced the handout *Women's Health Coordination Better Birth Outcomes: Key Initiatives 2015*. The goal of the NICU Study is to better understand regional variations in costs and quality as it pertains to newborn care. Although not outlined in any legislation nor formally endorsed by the PAC, it is a project that was undertaken about a year and a half ago. Work on this project is being done with a number of different partners including the Dartmouth Institute for Health Policy and Clinical Practice and the UT School of Public Health for their research capacity and analytical expertise.

Dr. Goodman, Principal Investigator, Dartmouth, referenced the handout: *Improving the Identification of Quality and Value in Newborn Care in Texas Version 2.1 June 15, 2014 and Improving the Identification of Quality and Value in Newborn Care in Texas*.

There is not a lot of information about patterns of utilization, and need a better understanding of the different ways these neonates are being cared for from hospital to hospital. The study for the State of Texas focuses exclusively on the Medicaid population. This is the very beginning of the work to obtain test data, and latest data set was received last night. The overall project is three years in duration.

Highlights of member discussion included:

- Dr. Goodman noted the study has relied on hospital surveys to self-designate. He welcomes feedback, opinions, and consensus for how they should be identifying these hospitals.
- Risk adjustment is key for studying variation and two factors that Dr. Harvey has pointed to are prenatal care with numerous variables and out-born claims information that is critical for certain types of analyses. Looking at the literature in studying newborn care, there are widely different approaches taken for risk adjustment, and we will try to incorporate some of the best of the work that has been done.
- Medicaid claims data allows distinguishing differences in LOC between providers.
- As pediatricians and neonatologists, this raises different questions and are there opportunities to use this info to drive better standards or care or not?
- Even in countries with really planned healthcare resources such as England, the question is raised about what those resources are being used for. Would not be able to answer that until the data today.
- Most of the country is operating on that self-designation LOC system, and there have been no studies today that show that.
- Data is used from the location of highest LOC provided (e.g., intensive care).
- The data can support all kinds of analyses, but the budget may not support all the analyses.
- Dr. Savani asked about the ability to measure mothers and babies that were transferred. He added that this data set could model what the new designations would have an effect on. For each hospital, based on gestational age and birth weight for maternal transfers, how that would be affected by the new designations, and see if we could get a model that could be predicted.
- There are currently no plans to look at specific providers or hospitals, and hospitals are viewed anonymously.

Agenda Item 5: Planning Subcommittee Report on House Bill 2131 Subcommittee Requirements (continued)

Dr. Briggs called for further discussion regarding writing a letter to the Legislature regarding the title as Centers of Excellence in Fetal Diagnosis and Therapy.

- Dr. Stanley questioned whether it would be within the purview of the PAC to write a letter or make a recommendation to the Legislator that authored this bill pointing out issues with the timeline, and asking to reintroduce legislation to change the name to the Centers of Excellence in Fetal Surgery to avoid problems in the future. There is a lot of diagnosis and therapy provided, without doing surgery.
- Dr. Briggs summarized that the drafted letter from the PAC should not only include recommendations for the timeline and the composition of the H.B. 2131 FCOE subcommittee, but should also include the title change from Centers of Excellence in Fetal Diagnosis and Therapy to Centers of Excellence in Fetal Surgery.

Motion:

Dr. Briggs asked for a vote that the drafted letter sent forth from the PAC to the Legislator also include the title change from Centers of Excellence in Fetal Diagnosis and Therapy to Centers of Excellence in Fetal Surgery. With no nays, and no abstentions, the Council members unanimously approved the motion by a show of hands.

Agenda Item 8: Discussion on Maternal Levels of Care

Dr. Toy referenced the handout *Maternity Designation Level I*.

- Conceptually follow the neonatal levels of care and national guidelines.
- As far as the timeline, complete the maternity standards draft by December 2016 and hand it off for rules designation. Mirroring the Neonatal LOC, it will go easier on the Maternal LOC side. Begin with the national guidelines but also look at stakeholder input, rural areas, various types of practices, obstetricians, midwives, MFMs, then hand off final recommendations to DSHS by Spring 2017.
- There is a need to focus on maternity outcomes for reduction in mortality and morbidity, triage and transfers for best outcome for both mother and neonate, and quality improvement processes which are critically important.
- At the next meeting on January 26, 2016, the PAC will start on the Maternal LOC. Massive transfusion protocols require huge blood banking facilities that very few, if any Level I maternity units would have the ability to accommodate. Hospitals having quality policies and criteria in place, and also regional collaboration will be necessary to get the blood rapidly enough.
- In regards to quality assessment and process improvement, each facility will have to submit its policies and procedures. Then during the site visit, what the qualifications for outcomes measuring are, what the action plans to meet those regional and national standards are, and some outcomes will be defined, as far as the database. Ms. Guerrero and Mr. Ferrara will determine how these things will be obtained.
- Postpartum hemorrhage cannot be predicted and can happen in a Level I hospital. ACOG and other institutions want to have a protocol.
- Mr. Harrison noted that, with the exception of free-standing children's hospitals, all hospitals will have two surveys and this may be exhausting from a resource standpoint on these facilities. He requested consideration of hospitals having the option of scheduling a combined survey with each of the teams.
- The PAC is in consensus that the date of the designation needs to be changed. Dr. Briggs heard that this is going to be September 2020 and is what the PAC would recommend.

Public Comment:

- Dr. Ramsey agreed with having set protocols and guidelines for primary postpartum hemorrhage (PPH). We are starting to look at the data on the neonatal side and having a list of data elements needed would be helpful. Regarding the Fetal Center discussion, he challenged the Council to read committee opinion 501 from ACOG August 2011 and

reaffirmed by ACOG in 2014 document titled *Maternal Fetal Intervention and Fetal Care Centers*, and reinforce that the PAC should use comparable language, for example Fetal Care Centers. Dr. Ramsey read from a document which he will send to Mr. Williams:

- "Fetal Centers can exist in many forms, having developed through a variety of multi-disciplinary and collaborative relationships among pediatric subspecialists, MFM specialists and radiologists"...
- "Conflicts of interest may arise in providing fetal intervention services surgery because these services may be financially lucrative to the institutions that may benefit to them or the careers of the centers practitioners."
- "Establishment of Centers of Excellence for those procedures that are particularly challenging and rarely may help optimize fetal and maternal care."
- There are a few surgeries that are beneficial but the rest are experimental, and there are no national guidelines for fetal surgery.

Action Item:

- Mr. Williams will send out the document referenced by Dr. Ramsey to the Council members.

Agenda Item 9: Public Comment

Dr. Toy asked for public comment. No public comment was heard.

Agenda Item 10: Set agendas, dates, times, and locations of 2016 meetings

The next PAC meeting is scheduled for January 26, 2016.

Agenda Item 11: Adjourn

The Council adjourned at 3:01 p.m.

**Perinatal Advisory Council
Meeting #14 Meeting Minutes
Tuesday, January 26, 2016
10:30 a.m. to 3:00 p.m.**

**Brown-Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, Texas 78751**

Agenda Item 1: Call to Order

The Perinatal Advisory Council (PAC) meeting commenced at 10:30 a.m. with Dr. Eugene Toy serving as chair. Dr. Toy welcomed everyone to the meeting.

Agenda Item 2: Roll Call

Mr. David Williams called the roll and noted that a quorum was present for the meeting.

Ms. Cassandra Marx announced that the meeting was being conducted in accordance with the Texas Open Meetings Act.

Dr. Toy introduced Dr. Alyssa Molina of Eagle Lake, Texas as the new rural provider council member.

Table 1: The Perinatal Advisory Council member attendance at the Tuesday, January 26, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Blanco, Cynthia MD	X		Perez, Annette	X	
Briggs, Emily MD	X		Rivers, Sandra	X	
Cho, Frank MD	X		Saade, George MD	X	
Greer, Barbara	X		Speer, Michael MD*	X	
Guillory, Charleta MD	X		Stanley, Michael MD	X	
Harrison, Allen	X		Stelly, Christina	X	
Harvey, John MD	X		Toy, Eugene MD	X	
Hollier, Lisa MD	X		Woerner, Steve	X	
Molina, Alyssa MD	X		Xenakis, Elly MD	X	
Patel, Sanjay MD	X				

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

* Dr. Speer serves in an ex-officio capacity

Table 2: The Perinatal Advisory Council staff attendance at the Tuesday, January 26, 2016 meeting.

STAFF NAME	YES	NO	STAFF NAME	YES	NO
Ferrara, Matt		X	Collins, Shanece	X	
Guerrero, Jane	X		Stevenson, Elizabeth	X	
Lynch, David			Williams, David	X	

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 3: Approval of the Minutes (Meeting Nov. 17, 2015)

Dr. Toy called for a motion to approve the minutes of the November 17, 2015 meeting.

Dr. Frank Cho motioned to approve the minutes of the November 17, 2015 meeting.

Ms. Barbara Greer seconded the motion. The Council members unanimously approved the minutes by a show of hands, with no nays and no abstentions.

Agenda Item 4: Status of Draft Rules Proposed for Neonatal Levels of Care

Ms. Jane Guerrero, Department of State Health Services (DSHS), provided an update on the draft Neonatal Levels of Care (LOC) rule process. Highlights of the discussion were as follows:

- Ms. Guerrero noted that DSHS has received numerous public comments including comments from 7 individuals, 1 State Representative, 15 from various facilities, and 13 from organizations. She stated that the public comment period has ended.
- The next step is for the rules to go to the Assistant Commissioner then to the Office of General Counsel to ensure any changes that have been made are within DSHS authority as well as to wordsmith for clarity. Following this, it will move up in an adoption request for publication to the Texas Register as an adopted rule. It is approximately 60 days from being published in the Texas Register as adopted, then the rules will be effective another 20 days following that publication.
- Changes to the rule language are noted along with the public comment which prompted the change. Generally, changes may be clarification or rewording, but are not substantive to change the overall intent of the rule.
- Dr. Toy asked to enter into public record the two correspondences the Council provided to DSHS as a formal response. The first was a tabular correspondence entitled *Texas HHSC Perinatal Advisory Council Comments to PROPOSED NEONATAL DESIGNATION RULES (submitted 12/14/2015)*. The second, entitled *Texas HHSC Perinatal Advisory Council Comments on Proposed Neonatal Designation Rules (Level I facilities)*, addresses the flexibility requested by some Level 1 facilities, especially in rural areas, in the treatment of infants with a gestational age of less than 35 weeks. After careful consideration and review of the scientific literature, the Council noted that because of issues that late preterm babies can face, and based on national guidelines, there is good reason to maintain the gestational age of 35 weeks and above for Level 1 facilities. The document also clarified recommendations for transportation of these infants. Dr. Toy noted that both documents are available for review on the HHSC website.

Public Comment:

Dr. Ekta Escovar, board certified rural pediatrician, read from a written statement which was provided to members. She is the only pediatrician in the Big Bend area of west Texas with a service population covering a 10,000 square mile area. Dr. Escovar trained for three years at a Level III hospital, but currently works at a 25-bed Level I facility with a Level I nursery in Alpine, Texas. She noted the challenges associated with being a small rural hospital in an isolated setting including limitations of time and ability to transport when the nearest NICU is 350 miles away. There is a balancing act of weighing a newborn potentially having a condition that cannot be managed with managing the mother and newborn within the hospital. Dr. Escovar urged Council members to maintain recommendations in line with national guidelines that Level I facilities should only care for babies of 35 weeks and above for the best possible outcomes including quality of care and keeping the family units together.

- Due to the remote location, some conditions require keeping infants in the hospital because patients live a few hours away and return visits may be a challenge.
- The facility uses a lot of phone call follow-up with maternal-fetal medicine (MFM) such as having protocols faxed over for medications or labs to be drawn to begin medical care for the baby before transfer. Depending on the situation, telemedicine is useful though it is not set up at this facility yet.
- In general, 40 percent of patients that were transferred had no prenatal care and 60 percent may have had prenatal care and delivered early although there is some

variation and about one-third of those with prenatal care may have shown initially at their 30 week visit.

Dr. Toy thanked Dr. Escovar for her articulate input and asked to utilize her as a resource for the Council.

Dr. Toy referenced the handout *Regional Advisory Councils - DRAFT (version 3.0 - Jan 22, 2016)* and noted that the Neonatal rules stipulate that every hospital seeking designation must show participation in their perinatal regional advisory council. Ms. Guerrero has contacted the trauma regional advisory council leadership and they have made inquiries to reach out to local facilities. There should be some obstetrical and neonatal representatives in the region to meet with the trauma regional advisory councils to notify and communicate with the various hospitals and schedule a meeting.

Dr. Toy noted that the individual region is the most efficient means to communicate widely, using hospital associations and professional organizations for pediatric, obstetric, and family medicine. Perinatal ad hoc committees in the region should be formed immediately in coordination with the trauma RAC leadership for that reason.

Two organizations have been identified for the review process for LOC designations including the American Academy of Pediatrics (AAP) and the Texas EMS Trauma and Acute Care Foundation (TETAF). TETAF is a Texas organization, independent of state agencies, that does the trauma and stroke surveys for designation. The national organizations generally use professionals from outside the state to do surveys. TETAF is an independent foundation and exclusively uses currently practicing professionals within the state. There are requirements in the rules stating that surveyors may not come from the same region, have no conflict of interest, and must meet the minimum requirements for the survey teams. Both of these organizations are gearing up for the surveys.

Concern was expressed that since this is an important discussion topic, Dr. Toy moved to have further discussion on this issue after lunch.

Agenda Item 5: Status on House Bill 2131 Subcommittee recruitment

Dr. Toy noted that due to concerns expressed at previous meetings, further discussion was warranted regarding the Centers of Excellence designations. Dr. Toy deferred to Dr. Briggs to chair the discussion in collaboration with Dr. Cho.

Dr. Briggs referenced the document entitled *State Designation of Advanced Fetal Therapy and Surgery Centers: Exploring the Public Health Need and Potential Unintended Consequences [Texas Perinatal Advisory Council Second Draft vers. 2.1 - For Discussion (Jan 25, 2016)]*

Having no national standards to this issue, it is important to take in public comment and engage in robust input and debate to be cognizant of potential unintended consequences. The PAC is not specifically vetting comments for validity because this is the initial discussion point.

- Advanced fetal therapy and surgery is an emerging field that has great potential but also may carry significant risks for both the pregnant mother and her affected fetus.
- The key components of designation are patient protection, informed consent based on ethical counseling, and transparency.
- Being mindful with an awareness of potential unintended consequences such as:
 - Concern for the proliferation of advanced fetal surgical centers without proper standards or evidence of efficacy.

- Standards may be too lenient.
- Concern about the transition plan when these procedures become mainstream such as EXIT (Ex Utero Intrapartum Treatment) procedures.
- Concern that geographic needs of the state may not be served.
- Concern about creating an artificial impetus to achieve designation.
- Concern that standards would be too restrictive and others cannot achieve designation other than through affiliation with an academic institution.
- Concern that designation creates a false public impression.
- Concern that the process does not require collaboration and collaboration benefits patients by allowing for analysis of data to demonstrate outcomes.
- Concern that designation may result in an unfair competitive advantage.
- Concern about the ramifications on payment. The bill does not state anything about payment but that concern has been voiced by many with regards to third party and other reimbursements.
- Other concerns include interference with routine diagnosis by MFMs and obstetricians, concern of procedures currently done routinely outside of academic institutions, and concern for the requirement of affiliation with a medical school for the purpose of commitment to research and advancement in the field and that purpose may not be achieved.
- Concern about the timeline completion by 2017 is too rushed, as well as concern that the title of designation as "Centers of Excellence" is erroneous due to a lack of requirement that outcomes are 'excellent'.

Highlights of member discussion include:

- Members agreed that from an ethical standpoint, the Centers of Excellence designation impacts such a small number of cases, so having the NICU and maternal LOCs in place first is a very important issue that the Council may need to appeal to the state to resolve.
- Most cases that require fetal surgery need a Level 4 facility and having designations in place first is crucial.

Public Comment:

Dr. Rashmin Savani, UT Southwestern Medical Center, Dallas, cautioned the Council about putting the EXIT procedure in the same category with intrauterine transfusion and shunt placement. Although the EXIT procedure is becoming more mainstream, the expertise far exceeds the other procedures. Dr. Savani added further caution about doing this procedure in lower level facilities where subspecialty supports may not be available.

Dr. Kenneth Moise Jr., with The Fetal Center at Children's Memorial Hermann Hospital and the University of Texas (UT) Medical School in Houston, helped craft some of the language of the bill. When crafting the language, the intent of the bill was patient protection. Other centers were beginning to do procedures without adequate training and quoting national statistics, but there is a learning curve. The Society for Thoracic Surgery has a database to compare outcomes across facilities. The CDC has a database for IVF programs so patients can compare outcomes. There is nothing like that for fetal therapy and surgery even though it is a very innovative field with a small number of patients, it includes a sophisticated set of procedures. There is concern about the proliferation of centers as it pertains to patient safety. Fellowships in fetal intervention have now been developed because people doing these procedures should be trained. A group from Milwaukee is doing their homework to begin doing open surgery with Spina bifida, and they are visiting and training with doctors at UT in Houston, and will travel back to Milwaukee with those doctors to work on a case together. Taking these established procedures and implementing them in a greater geographic area needs to be worked out as part of that system. There are concerns being raised about geographic issues in Texas with smaller towns transporting patients to these facilities. These procedures are not done that often and it takes an entire

team with expertise to do this. We have not dealt with major concerns with insurance companies and Medicaid in other states to get patients to the right place and they are also assisting with transport, then taking patients back to follow up with their referring MFM doctors.

In crafting the bill, the goal was not to take away all the other great work being done by MFMs and radiologists for minor procedures throughout Texas. There will be more procedures coming online in the next year or so such as fetoscopic repair for spina bifida is on the horizon. Dr. Moise's final point concerning the discussion about waiting until after the maternal level designation, it is felt this could be a parallel process. The majority of these mothers are healthy and maternal comorbidity is a contraindication to fetal intervention. Having the highest level of maternal care being part of the fetal center designation is unnecessary.

- The intent of the bill was not intended to include only new and improved procedures. For example, for laser for twin-to-twin transfer syndrome (TTTS) the learning curve is approximately 75 cases. To have a center simply open up and begin performing this procedure, it is unethical for patient care. There are fellowships established for learning those procedures, and new American Congress of Obstetricians and Gynecologists (ACOG) guidelines for established procedures. New procedures should be done at teaching hospitals where positive outcomes can be maintained based on higher volume.
- Concern was expressed that the credentialing process may not allow for adequate oversight to yield optimum outcomes.
- The term 'Centers of Excellence' was not intended to create a marketing strategy but to create transparency to give patients great care, and he personally was open to another designation name.
- The intent of bill was to outline some basic tenets of what a fetal center would be. New centers are recruiting new doctors, and fellowships allow doctors to come in with new training as older doctors retire.

Dr. Patrick Ramsey, San Antonio, provided oral and written comments.

The summary document reviewed cites "The purpose of designation of these centers is to best serve our patients and ensure that they receive accurate information, ensure a high level of multi-disciplinary care for these patients, and to carefully document outcomes in a scientific way to advance knowledge in this field." This stated purpose aligns well with the content of House Bill 2131; however, focus has shifted from "Centers of Excellence for the Fetal Diagnosis and Therapy" to "Advanced Fetal Therapy and Surgery Centers".

1. In analyzing the thematic construct Centers of Excellence versus Advanced Fetal Centers, what do we want for our patients, excellent quality or advanced procedures?
2. The heavy focus regarding Fetal Therapy and Surgery rather than the intended spirit of the legislation "Fetal Diagnosis and Therapy" where the goal is serving the woman of Texas, the sole focus of surgery versus therapy does not meet the interests of this bill.
3. H.B. 2131 mentions four core criterion, including offering fetal diagnosis and therapy associated with a teaching hospital in the state, second a commitment to research to advance the field, third to offer advanced training programs in fetal diagnosis and therapy, and fourth, integrates the program with a long term follow-up,

There are five programs in Texas with affiliated fellowship programs in maternal-fetal medicine so this should not be a proliferation of centers if the intent of the bill is followed.

There was also discussion that many non-academic institutions in Texas provided excellent fetal diagnosis and therapy.

Agenda Item 6: Lunch

The Council recessed for lunch at 12:17 p.m. and reconvened 1:04 p.m.

Agenda Item 5: Status on House Bill 2131 Subcommittee recruitment (continued)

Public Comment:

Dr. Robyn Horsager, UT Southwestern Medical Center, thanked Dr. Ramsey for his comments about drawing the attention back to the original language of the bill focusing on comprehensive care. Women are faced with the choice to go to a center for intrauterine surgery where risks are too high, travel is prohibitive, or outcomes may not be adequate, or risk delivering at a center where a similar team will perform the procedure postnatally. In defining COE as focusing only on in-utero procedures, this limits information a woman has to make an informed decision. Additionally, many women may not want to participate in a research trial, and may not have the information for an alternate facility where the procedure can be done. The numbers are rising, and approximately 5.5 percent of all live births have a congenital anomaly so there is a need to address care for that larger group of infants who will disproportionately require resources, with a comprehensive view of fetal care and neonatal care. A broader position of transparency is needed to include volumes, fetal outcomes, and a category for neonatal outcomes for those patients who choose not to have an intervention, to give women the big picture in order to make an informed decision about their care.

Highlights of member discussion include:

- Fetal diagnosis encompasses a lot of maladies whereas fetal therapy encompasses only a few diagnoses. The fetal centers could be considered as a place for a second opinion. The expertise builds as you get a wider referral pattern.
- ACOG does not mention this, but the bill allows the medical school to set up a formal fellowship program, then whether it is MFM or fetal intervention training, the infrastructure is there for both teaching and research. A clinical center can also perform research, but this position needs a formal training program that is recognized by GME. The bill does not address whether the training has to be onsite or it may be located elsewhere.
- If the purpose of this is patient protection, information about outcomes and volumes should be on the facility websites. Patients should be able to look at the website to see a transparent list of number of procedures, who the providers are, and what the outcomes are.
- Ms. Guerrero is putting information together about the H.B. 2131 Subcommittee. It is not a subcommittee directly affiliated with this Council but is appointed by DSHS.

Agenda Item 7: Discussion on Maternal Levels of Care

Dr. Toy referenced the document *PAC - Maternity Designation - Level 1 DRAFT (Jan 22, 2016) vers 1.0*.

- As long as the hospital has someone readily available as well as guidelines and policies in place, it may not need to be a requirement that the medical director is ACLS certified. There was consensus regarding this proposal.
- A Certified Nurse Midwife (CNM) with appropriate physician backup, to clarify that the physician has to have additional credentials, and both the CNM and the physician must arrive at the bedside in a timely manner. There is the possibility of a CNM being present at every level of facility.
- Consultants are few and far between especially in rural areas and may be the only resource available. At a minimum, telephonic access would be important.

- ACOG is very clear about keeping adequate blood supplies for a level 1 facility due to the frequency of post-partum hemorrhage (PPH).
- Rural facilities do not keep enough blood on hand and when there is a hemorrhage the blood is not there. These facilities should have a plan due to limited availability of units of blood and limited expedient access to the next closest bank.
- It is not common for an obstetrics unit to run drills or have a plan in place. California came up with a toolkit to help with this concern.
- The Texas Collaborative for Healthy Texas Mother and Babies can help work with developing guidelines.
- Ms. Robyn Horsager noted that those diagnoses will be transported to a higher level facility depending on where the Level 1 is located and what their capabilities are.
- Dr. Toy responded that the PAC is working to get those Neonatal LOC outcomes finalized, because it is important to have and promote meaningful data.
- The University of Texas has access to funds which may be used to initiate setting up the database.
- Dr. Holier is Chair of the Texas Morbidity and Mortality Review Board and they have been looking at those outcome variables.
- For trauma, every level of care submits to the state registry. Currently, with stroke, the state does not have the authority to obtain that info in a registry.
- Vermont Oxford Network (VON) is an excellent database and can do risk adjustment. A small 25 bed NICU may crunch data in an Excel spreadsheet instead, due to cost associated with VON. VON can work well for Level 2 and 3 facilities but Level 4 facilities may see really diverse diagnoses so there is a Neonatal Database used as a referral database.
- Quality improvement is ongoing and needs to happen continuously. The state wants an annual report card and last year the California Perinatal Quality Care Collaborative (CPQCC) put all those databases into one and has been shown to improve outcomes.
- The data that is sent to the state trauma section is really secure. The Epidemiology staff are providing statistics and if facilities can go in and have data pulled back out it can be requested.
- For designation, it is a requirement to submit to the registry with the state. Facilities do not have to show improvement in the data that is put in the registry.
- The database was set up for EMS and hospital providers and submitted particularly for trauma and could be used for quality improvement.
- Not all hospitals belong to VON and CPQCC has been instrumental in improving outcomes. Funds that were spent with that collaborative database have saved the state of California money.
- Dr. Speer noted that the Texas Collaborative is taking off and would mirror the CPQCC and the pediatric database. It could be used for quality improvement.
- VON is a very comprehensive database with only four of five items and it is important to not overcomplicate it. It does not have to be an elaborate database but there are four or five things that would be important to consider for outcomes.
- There was discussion regarding site visits and Ms. Elizabeth Stevenson answered these questions: AAP indicated they would like to survey Levels 2 through 4 and TETAF would like to survey Level 2 facilities.
- It is important that the representation by the American Academy have a balance between those in clinical practice and those in academic institutions.
- Level 3 and 4 surveys will be done by the AAP so will not have an in-state survey team.
-

Action item:

- Mr. Williams and Ms. Marx will resolve issues with the projector screen for the next meeting.

Agenda Item 8: Public Comment

No additional public comment was heard at this time.

Agenda Item 10: Set agendas, dates, times, and locations of 2016 meetings

The next PAC meeting is scheduled for March 29, 2016.

Agenda Item 11: Adjourn

The Council adjourned at 3:15 p.m.

DRAFT - NOT APPROVED

**Perinatal Advisory Council
Meeting #3 Meeting Minutes
Tuesday, March 29, 2016
10:30 a.m. to 3:00 p.m.**

**Brown-Heatly Building
Public Hearing Room
4900 North Lamar Boulevard
Austin, Texas 78751**

Agenda Item 1: Call to Order

The Perinatal Advisory Council (PAC) meeting commenced at 10:31 a.m. with Dr. Eugene Toy serving as chair. Dr. Toy welcomed everyone to the meeting.

Agenda Item 2: Roll Call

Mr. David Williams called the roll and noted that a quorum was present for the meeting.

Table 1: The Perinatal Advisory Council member attendance at the Tuesday, March 29, 2016 meeting.

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Blanco, Cynthia MD		X	Perez, Annette	X	
Briggs, Emily MD	X		Rivers, Sandra	X	
Cho, Frank MD	X		Saade, George MD	X	
Greer, Barbara	X		Speer, Michael MD*	X	
Guillory, Charleta MD	X		Stanley, Michael MD	X	
Harrison, Allen	X		Stelly, Christina		X
Harvey, John MD		X	Toy, Eugene MD	X	
Hollier, Lisa MD	X		Woerner, Steve	X	
Molina, Alyssa MD		X	Xenakis, Elly MD	X	
Patel, Sanjay MD	X				

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

* Dr. Speer serves in an ex-officio capacity

Table 2: The Perinatal Advisory Council staff attendance at the Tuesday, March 29, 2016 meeting.

STAFF NAME	YES	NO	STAFF NAME	YES	NO
Collins, Shanece		X	Stevenson, Elizabeth	X	
Guerrero, Jane		X	Williams, David	X	

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

Agenda Item 3: Approval of the Minutes (Meeting January 26, 2016)

Dr. Toy called for a motion to approve the minutes of the January 26, 2016 meeting. Dr. Emily Briggs motioned to approve the minutes. Ms. Barbara Greer seconded the motion. The Council members approved the minutes by unanimous voice vote.

Agenda Item 5: Perinatal Advisory Council (PAC) guiding principles

Mr. Williams, Health and Human Services Commission (HHSC), referenced the document entitled *Perinatal Advisory Council Guiding Principles* provided to members. In light of new members added to the Council as well as new rule changes for existing advisory committees, Mr. Williams presented information on the updates to the document. The new rule governing the PAC will become effective September 1, 2017. Additional revisions may need to be made to the guiding principles at a later date. Highlights of the update include:

- Previously, the Council chair was selected by the HHSC executive commissioner and one change is that PAC members will elect a presiding officer from the membership themselves.
- The members may re-elect the same chair.
- Members may re-apply to be on the Council again.
- Members will be replaced in the capacity they serve. For example, a nurse from a rural region will be replaced with another nurse from a rural region.

Motion:

Mr. Allen Harrison moved to accept the updated guiding principles. Dr. Frank Cho seconded the motion. The motion carried via unanimous raised hand vote.

Action Items:

- Mr. Williams will provide members with a list of member term expirations, as well as the replacement schedule for members on the council.

Agenda Item 6: PAC Report due Sept. 1, 2016

Dr. Toy referenced the handout entitled *Perinatal Advisory Council Annual Report* and provided an update. Member discussion highlights are as follows:

- The report is due September 1, 2016, as House Bill (H.B.) 3433 gave an extra year for the report to be submitted.
- The report will include content such as an executive summary, authorizing legislature, formation and composition of the council, background, formal council recommendations, and future committee activity.
- The report will be developed by June 2016 and a draft version will be circulated to members. The draft from the council will be due in late July and a version will be finalized in August and submitted to the staff for formatting, to be in compliance with the submission deadline.

Action Items:

- Prior to the next meeting, council members are asked to review the report for content and completion at the available link on the website.

Agenda Item 7: Updates from PAC Chair*

Dr. Toy reviewed the PowerPoint and provided an update as PAC Chair. Member Discussion highlights are as follows:

- Best practices, or those that exceed the standard, have been examined and the national guidelines have been taken and adapted for Texas with stakeholder input.
- Once those standards are drafted, they will be submitted to the state, and the PAC will refer all questions concerning the rules, standards, and compliance to Ms. Jane Guerrero and her office at the Department of State Health Services (DSHS), so as to cut down on the dissemination of incorrect information.
- Testimony provided by Dr. Ekta Escovar from Alpine, Texas detailed challenges she regularly encounters as she upholds the best practices in a rural setting.
- Best practices were also discussed for topics including guidelines for the post-partum hemorrhage cart, the Pyxis system, and massive transfusion protocols. Collaboration and coordination of efforts was identified as key to this endeavor.
- Dr. Saade raised concerns about requiring protocols for best practices, as this was not required for neonatal levels of care rules. Dr. Charleta Guillory and Ms. Annette Perez expressed the importance of having a policy in place.
- Dr. Toy acknowledged that discussion of these issues will be ongoing and input is desired. He encouraged council members to forward helpful best practices to members of the council.

- Dr. Hollier reminded members that the National Council on Patient Safety and Women's Healthcare has developed several safety bundles that are available for download. Information can be found at safehealthcareforeverywoman.org.
- Concerning Perinatal Regional Advisory Councils, H.B. 15 stipulates the state be divided into perinatal regions for not mandated, but stated transfer agreements. Ms. Guerrero and staff believe it would be best to put perinatal regions within the current trauma regions due to the existing structure and framework. Prior to application, it is required that each region set up a Perinatal Regional Advisory Committee (RAC) structure. Dr. Toy previously asked members to communicate with the leadership in the local trauma regions and then by June or July, adopt rules for what the structure will be.
- Ms. Greer gave an update on workgroup activity of the Central Texas RAC. Mr. Harrison similarly updated the committee on the activity of the Capitol Area RAC. Mr. David Reimer, Executive Director of the Capitol Area Trauma RAC (CATRAC), gave an in-depth update on activity of the group, including the creation of a workgroup.
- Although Trauma Regional Advisory Councils have the word "trauma" in the name, they are not limited to issues dealing with trauma. The organizations started out as trauma organizations but have evolved to deal with the whole healthcare system.
- Dr. Toy stated that processes are being set in relation to each area's own standards. The scope of the committee is to be discussed with Trauma RAC leadership, and the purview of the committee was defined by Dr. Toy as giving guidance temporarily so the structure can be approved by the voting members.
- Perinatal RACs may be able to partner with other perinatal RACs due to limited number of facilities and there is no bylaw restricting this.
- Ms. Guerrero and Ms. Elizabeth Stevenson should be contacted for specific questions about logistics and set up of RACs since DSHS contracts with the Trauma RACs and they have the information and authority.

Agenda Item 8: Lunch (Recess)

The Council recessed for lunch at 11:58 a.m. and reconvened 1:01 p.m.

Agenda Item 9: Discussion on Maternal Levels of Care*

Dr. Toy reviewed the document entitled *PAC - Maternity Designation - Level 1 DRAFT (March 21, 2016) vers 5.0* and made revisions based on the discussion.

- Maternal level of care is needed due to the maternal mortality rate in Texas increased 3-fold in the last 12 years, and being above the national average, and because this area of maternal levels of care is a new concept, despite being included in perinatal guidelines.
- The document is consistent in keeping with the neonatal rules. The reason the neonatal part is included is because someone must be cognizant of the possibility of neonatal issues. The neonatal rules have not been released, so this may change, but this is based on what was posted in the Texas Register on November 20, 2015.
- It was noted that maternity designations do not currently include birthing centers, as they are regulated by another area.
- Some family physicians asked whether the medical director should be required to be certified in Advanced Life Support in Obstetrics (ALSO). Although this is a good program, Dr. Briggs stated that being this prescriptive would limit potential future programs.
- The state will be enforcing provisions via case reviews by surveyors and peers. This will be looked at during the survey for designation, not necessarily in the office, but also coming in at any point from a patient complaint. There is not a protocol that

the state may utilize. The state may come in at any time if there is program inadequacy, but it has not been looked at for how it would be done.

- Dr. Toy stated that the guidelines drafted by the MMD or physician can be reviewed by the MMD to ensure that it fits within the hospital's guidelines.
- A public comment was received from Ms. Cheryl Bonecutter from the University Health System, who gave a suggested adding a statement about midwifery practice according to the Texas Administrative Code and a review of those guidelines.
- The importance of having centralized monitoring in place was expressed by Ms. Elaine Sager, a public stakeholder, who suggested if doing OB services, machines should be in place for each laboring woman. This would require the physician to be present, but this could be handled through training, for example, from nurses who interpret electronic fetal monitoring at home.
- According to Dr. Toy, with maternal mortality increasing three-fold, issues can be managed at facilities with available equipment, and it is important to have the ability to consult. However, this must be flexible enough that facilities state-wide ensure that consultation occurs.
- According to Dr. Toy, some of the maternity requirements are a bit of a departure from the neonatal approach, but as neonatologists have using national standards and levels of care for years, this is the first attempt to raise the maternity level to what it should be. Additionally, although there is not a paragraph addressing quality improvement, Dr. Xenakis expressed the importance of hospitals having policies to address this. Dr. Hollier stated that she thought the safety bundle guidelines would help decrease maternal morbidity and mortality. There was general agreement with the maternal safety guidelines.
- Concerning training, Ms. Perez stated that guidance is needed in how to address high-risk and low frequency situations, as there are high cost simulations that can be less expensive so as to not be overly prescriptive.

Agenda Item 4: State Neonatal Care System Report, Office of Emergency Medical Services and Trauma Systems Coordination

Ms. Stevenson, DSHS, provided an update on the state neonatal care system report.

Member discussion highlights are as follows:

- The H.B. 2131 subcommittee received a lot of applications for the positions, except from the public members, so those will remain vacant. Those recommendations will be sent to the Executive Commissioner and the timeline will remain fluid. Approximately 40 applications were received for all positions.
- For the neonatal and the rules packet, which is included, the effective date will be sometime in May and the application will not be posted until September 1, 2016. During the summer, training and compliance will be conducted for doctors and providers via face-to-face meetings and webinars.
- Survey organizations will conduct a survey and still have two from TETAF and AAP. Formal approval has not yet been received to determine the final survey organizations.
- Although both TETAF and AAP have interest in doing all three levels, Dr. Spear strongly urged the state not to have non-pediatric surveyors.

Action Items:

- Ms. Stevenson will find out from Ms. Guerrero whether vacant positions in the subcommittee can be applied for currently, or whether they will remain vacant.

Agenda Item 9: Discussion on Maternal Levels of Care* (continued)

Dr. Toy referenced the document entitled *PAC - Maternity Designation - Level 2 DRAFT (March 20, 2016) vers 2.0* and made updates according to the discussion.

Dr. Toy continued the discussion on maternal levels of care and highlights included:

- Discussion was conducted whether providers should be both board eligible as well as board certified. According to Dr. Toy, the council should look at a variety of hospitals and settings so as to not make a rule that sounds good, but ends up hurting a lot of facilities. Additionally, line 43 will transfer all the phrasing from the Level I designations.
- In Line 83, in an attempt to classify what should be contained in the blood bank, specific blood products must be provided for the higher-risk facilities, and this must be specified.

Agenda Item 10: Public Comment

No additional public comment was recorded at this time.

Agenda Item 11: Announce dates, times, and locations of upcoming meetings in 2016

The next PAC meeting is scheduled for May 2, 2016.

Agenda Item 11: Adjourn

The Council adjourned at 3:03 p.m.

DRAFT - NOT APPROVED

2 **FOR CLARITY, PLEASE REFERENCE THE PAGE NUMBER AND LINE NUMBER(S) WHEN YOU SUBMIT A**
3 **RECOMMENDED CHANGE WITH THE RATIONALE. EMAIL TO Eugene C. Toy, MD, Chair Texas**
4 **Perinatal Advisory Council: ECTOY@HOUSTONMETHODIST.ORG**

4 **Contents**

5 **Introduction** (Guiding Principles, Primary Sources, Purpose of guidelines)

6 I. Overview of Neonatal Levels of Care

7 II. Definitions (see attached)

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9 III. Level I Neonatal Level of Care

10 a. Capabilities

11 b. Health care providers

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13 d. Perinatal Service Plan

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33 VII. Quality Improvement, Data Collection, and Reporting

34 VIII. Home or Reverse Transfers

35 IX. Equitable payment for services

36 X. Incentives for Quality

37 XI. Neonatal Level of Care Summary

38 XII. References

1 INTRODUCTION

2 This document represents the Texas HHSC Perinatal Advisory Council consensus recommendations to
3 adapt national neonatal levels of care guidelines to the care of neonates in Texas. In developing these
4 recommendations, the Perinatal Advisory Council reviewed many documents, heard from many
5 stakeholders, and reviewed the effect of various requirements on different communities. Substantial
6 evidence demonstrates improved survival and morbidity outcomes for very low birth weight (VLBW)
7 infants born at a level III or IV facility; in Texas, less than half of VLBW infants are born at these higher
8 level hospitals. Education of health care providers and patients is paramount to correct this problem.
9 Additionally, a recent state survey suggested that many hospitals using self-designation may not meet
10 the criteria for various levels of care. Thus, state designation with verification is important to promote
11 the best care. Perinatal health care is challenging in Texas due to the state's large geographic area, the
12 contrast between urban and rural areas, and diversity of the population and cultures. These
13 recommendations are meant to empower physicians, caregivers, parents, and hospitals to provide the
14 most current evidence based care for infants within their community. The Council recommends a
15 judicious balance of strict application to ensure quality care, flexibility to avoid unintended harm during
16 implementation, and the use of reliable outcome measures to assess the effectiveness of healthcare
17 delivery.^{1 2}

18 **Guiding Principles**

19 The guiding principles used to develop the neonatal levels of care were:

- 20 1) Use of national guidelines such as those published by the American Academy of Pediatrics and
21 the American College of Obstetricians and Gynecologists as the primary foundation for this
22 document
- 23 2) An appreciation of stakeholder input and consideration of the diverse communities and
24 geography of the state
- 25 3) Consideration of the special challenges facing rural hospitals and healthcare providers^{3 4}
- 26 4) Seeking to provide the appropriate level of care for the mother and/or baby in the appropriate
27 place and at the appropriate time^{5 6 7}
- 28 5) Whenever possible, keeping mothers and babies close to home and their support systems
- 29 6) Ensuring safe transport of mothers and babies between facilities
- 30 7) Incorporating evidence based recommendations whenever available
- 31 8) Encouraging a consistent standardization of levels of care and encouraging the education of
32 healthcare providers and consumers about the levels of care
- 33 9) Recommending appropriate reimbursement for services provided including payment for transfer
34 back to the home institution ("home" or "home facility" transfers) and telemedicine consults
- 35 10) Mothers and infants should be cared for in Texas unless the required services are not available at
36 a facility in Texas within a reasonable distance.

37

1 **Primary Sources**

2 The American Academy of Pediatrics (AAP) new policy statement for neonatal levels of care, a
3 recognized national standard, was published in September 2012.⁸ The *Guidelines for Perinatal Care 7th*
4 *Edition*, which corresponds to the AAP policy statement and expands on requirements, was published in
5 October 2012 and is a joint effort between the AAP and the American College of Obstetricians and
6 Gynecologists (ACOG).⁹ The AAP 2012 Levels of Care policy and the *Guidelines for Perinatal Care 7th*
7 *Edition* incorporate new evidence based recommendations and levels of care that are considerably
8 different from the previous guidelines.¹⁰ The Council recommendations are based on the 2012 AAP
9 Levels of Care Policy Statement and the *Guidelines for Perinatal Care 7th Edition*. We would advise that
10 future recommendations should likewise be based on these and/or other nationally recognized
11 publications.

12 **Purpose of Guidelines**

13 The guidelines are general and intended to be adapted to many different situations, taking into account
14 the needs and resources particular to the locality, the institution, or type of practice. Variations and
15 innovations that improve the quality of patient care are to be encouraged rather than restricted. The
16 purpose of these guidelines will be well served if they provide a firm basis on which local norms may be
17 built. (⁹ p ii) These guidelines also specify some staffing or facility physical requirements. Pre-existing
18 state or regulatory standards dealing with staffing or facility specifications should be used unless obvious
19 patient safety or patient care reasons are present.

20

- 1 **I. OVERVIEW OF NEONATAL LEVELS OF CARE**
- 2 a. Level I Neonatal level- infants \geq 35 weeks with routine, transient perinatal problems
- 3 b. Level II Neonatal level - infants \geq 32 weeks and birth weight \geq 1500 grams, able to provide
- 4 mechanical ventilation for a brief duration (< 24 hours) or continuous positive pressure or
- 5 both, able to stabilize infants < 32 weeks until transfer to a Level III/IV NICU
- 6 c. Level III Neonatal level – care for infants of all gestational ages, provide sustained respiratory
- 7 support as needed, provide prompt and readily available access to a full range of pediatric
- 8 medical subspecialists, anesthesiologists with pediatric expertise, pediatric surgical
- 9 specialists, and readily available means of evaluating and treating ROP such as having access
- 10 to a pediatric ophthalmologist or an ophthalmologist with ROP expertise. (p12)
- 11 d. Level IV Neonatal level – care for infants of all gestational ages, able to provide surgical repair
- 12 of complex congenital or acquired conditions, maintain a full range of pediatric medical
- 13 subspecialists, pediatric surgical subspecialists, and pediatric anesthesiologists at the site.
- 14 e. Need for transfer- while the goal and hope is for the VLBW baby to be delivered at the
- 15 appropriate facility (level III/IV), it is recognized that occasionally due to unforeseen
- 16 circumstances, such an infant may be born at a lower level facility, such as a level II facility.
- 17 Stabilization and transfer to the appropriate level facility should be accomplished safely and
- 18 in a timely manner; in rare circumstances, the VLBW infant at the upper end of weight
- 19 spectrum that is stable and otherwise uncomplicated may be safely cared for at the level II
- 20 facility with consultation with the higher level facility. This practice however should not be a
- 21 common practice and should not be a routine.
- 22
- 23

- 1 II. **Level I NEONATAL CARE-** All hospitals with a delivery service have a family centered philosophy.
2 Parents have reasonable access to their newborns 24 hours a day and are encouraged to
3 participate in the care of their newborns. In most cases the newborn can be cared for in the
4 mother's room. The hospital environment for perinatal care should meet the physiologic and
5 psychosocial needs of the mothers, newborns, and families.
6
- 7 a. Level I Capabilities: All hospitals with a delivery service shall have skilled personnel with
8 appropriate training and competencies and equipment to perform the following functions:
- 9 i. Triage and assess all patients admitted to the obstetric service and identify high risk
10 patients who should be transferred to a higher level of care prior to delivery. Each
11 level I hospital has written Triage and Transfer Guidelines.
- 12 ii. Provide supportive and emergency care for unanticipated maternal-fetal problems
13 that occur during labor and delivery
- 14 iii. Provide anesthesia for maternity care, pharmacy, radiology, respiratory support,
15 electronic fetal heart rate monitoring, and laboratory services on a 24 hour basis
- 16 1. Device for blood glucose screening
- 17 2. Portable x-ray and ultrasound equipment available to Nursery within 30
18 minutes
- 19 3. Performance and interpretation of neonatal x-rays and perinatal ultrasound
20 available 24hrs/day and 7 days/wk
- 21 4. Laboratory technician available 24 hrs/day and 7 days/wk in the hospital or
22 within 30 minutes
- 23 5. Capability of reporting laboratory results in a timely fashion
- 24 6. Blood bank technician on-call and available within 30 minutes for performance
25 of routine blood banking procedures; provision of emergent availability of
26 blood and blood products
- 27 7. Respiratory care practitioner as prescribed by the medical director and clearly
28 delineated by written protocol.
- 29 8. Registered pharmacist immediately available on site or by telephone
30 consultation 24 hours/day and 7 days/wk; provision of medications 24 hr/day
31 and 7 days/wk, and having immediate access to emergency drugs
- 32 9. Intrapartum, postpartum, and newborn care should be supervised and
33 delivered by a registered nurse. (pp30-31)
- 34 iv. Availability of postpartum care provider with expertise in lactation
- 35 v. Evaluate and provide care for physiologically stable infants ≥ 35 wks and their
36 continuing care until discharge
- 37 vi. Follow guidelines as established by the Neonatal Resuscitation Program (NRP) of the
38 American Heart Association/American Academy of Pediatrics for the resuscitation of
39 all infants

- 1 1. Provide neonatal resuscitation at every delivery. Each birth attended by at
2 least one NRP trained person whose only responsibility is the management of
3 the newborn. Additional personnel capable of performing a complete
4 resuscitation is in-house and immediately available who holds a current NRP
5 provider card and capable of assisting in chest compressions, intubation and
6 administering of medications.⁹ (p 23-24)
- 7 2. The following basic equipment and supplies must be immediately available to
8 perform an initial resuscitation and stabilization on any infant (p45):
 - 9 a. Radiant warmer
 - 10 b. Noncompressible resuscitation and examination mattress that allows
11 access on three sides
 - 12 c. Wall clock with second hand or digital clock
 - 13 d. Table or flat surface for trays and equipment or appropriate space for
14 electronic record documentation
 - 15 e. Dry, warmed linens
 - 16 f. Stethoscope with neonatal head
 - 17 g. IV catheters, fluids, and supplies; syringe, medications (epinephrine,
18 dextrose solution), crystalloid solutions for volume expansion, and
19 normal saline for flushes
 - 20 h. Code box with current neonatal medications
 - 21 i. Respiratory equipment -
 - 22 i. Pulse oximeter with neonatal oximetry probes
 - 23 ii. Cardio-respiratory monitor
 - 24 iii. Blended air/oxygen in delivery room and nursery
 - 25 iv. Facemasks for blow-by oxygen
 - 26 v. Laryngoscope with 0 and 1 blades
 - 27 vi. Endotracheal tubes (2.5-4.0 mm), and tape; meconium
28 aspirator;
 - 29 vii. Ventilator device: self inflating bag, flow-inflating bag, or T-
30 piece ventilation device that is capable of delivering 90-100%
31 oxygen and continuous positive airway pressure; a self inflating
32 bag is capable of back up; or ventilator capable of neonatal
33 settings and CPAP; masks for term and preterm infants, carbon
34 dioxide detector; device and appropriate size cuffs for assessing
35 blood pressure
 - 36 viii. Bulb syringe, mechanical suction, tubing, and suction catheters;
 - 37 j. Umbilical line tray- sterile
 - 38 k. Supplies for needle aspiration of chest
 - 39 l. Protective gear to prevent exposure to bodily fluids

- 1 m. Special equipment for surgical care (eg bowel bag for gastroschisis,
2 donut for neural tube defect) or special circumstances (plastic wrap or
3 bag for very preterm newborns and transport incubator to maintain
4 temperature during the move to the NICU);
- 5 n. Task lighting that is capable of providing no less than 2,000 lux at the
6 plane of the infant bed and adjustable so that lighting at less than
7 maximal levels can be provided whenever possible
- 8 o. Phototherapy equipment available that produces irradiance of at least
9 30 uW/cm²/nm or ability to simultaneously cover body surface under
10 and over baby;
- 11 p. Irradiance meter to measure light irradiance of equipment
- 12 q. Device to measure blood gas in < 0.4 mL blood
- 13
- 14 vii. Stabilize ill infants or those born less than 35 weeks including unexpectedly small or
15 sick neonates prior to transfer to a higher level facility, following thermoregulation
16 and resuscitation guidelines per AHA Guidelines for Neonatal Resuscitation and
17 stabilization pending transfer to appropriate level of care facility based on neonatal
18 services required.
- 19 viii. Arrange transfers to a higher level of care in conjunction with their written guidelines
20 and transfer agreements
- 21 ix. The medical and nursing staff of any hospital must providing perinatal care at any
22 level should maintain knowledge about and competency in current maternity and
23 neonatal care through joint in-service sessions. The staff of each unit should have
24 regular multidisciplinary conferences to discuss patient care problems. (p.35) Regional
25 hospitals should assist the lower level hospitals in the educational endeavors.
26 Educational strategies are comprised of sessions such as lectures, audiovisual and
27 media programs, booklets, and clinical practice rotations. (p.36)
- 28 x. Staff education on newborn stabilization prior to transport, provided to all staff caring
29 for newborns via telephonic or computer technology or onsite.
- 30 xi. Social service/case management: mechanism available for high risk assessment and
31 provision of social services
- 32 b. Health Care Providers of Neonates-
- 33 i. A physician for the program shall be designated to assume primary responsibility for
34 initiating, supervising, and reviewing the plan of management for distressed infants.
35 Policies and procedures shall assign responsibility for identification and resuscitation
36 or distressed neonates to individuals who have completed a nationally recognized
37 neonatal resuscitation program and are both specifically trained and immediately
38 available in the hospital at all times, such as another physician, a nurse with training
39 and experience in neonatal resuscitation, or a respiratory care practitioner.
- 40 ii. Neonatologists, pediatricians, family medicine physicians, nurse practitioners (NP) or
41 other advanced practice registered nurses are identified are care givers.

- 1 iii. The nursery medical director is a board eligible/certified pediatrician, board
2 eligible/certified neonatologist, or board eligible/certified family medicine physician
3 with experience in the care of newborns.
- 4 iv. The nurse manager of perinatal and nursery services must maintain an RN license,
5 directs perinatal and/or nursery services; guides perinatal and/or nursery policy and
6 procedures; collaborates with medical staff; and consults with higher level of care
7 units as necessary. One RN may manage both perinatal and nursery services but
8 additional managers may be necessary based on number of births, average daily
9 census, or number of full time equivalents (FTEs).
- 10 v. Level I units have personnel who can care for physiologically stable infants, who are born at or
11 beyond 35 weeks of gestation, and can stabilize ill newborn infants, who are born at less than
12 35 weeks of gestation until they can be transferred to a facility where the appropriate level of
13 neonatal care is provided. (p. 14)
- 14 vi. Nursing care for healthy newborns should be provided by registered nurses who are trained
15 and qualified in caring for newborns. Direct care of newborns remaining in the nursery may
16 be provided by licensed vocational nurses or nursing assistants, supervised by a registered
17 nurse. (p48)
- 18 vii. Nurse: patient ratio (applies to all levels of nurseries I-IV)
- 19 1. Staffing parameters should clearly delineate in a policy that reflects (a) staff
20 mix and ability levels; (b) patient census, intensity, and acuity; and (c) plans for
21 delegation of selected, clearly defined tasks to competent assistive personnel.
22 It is an expectation that allocation of personnel provides for safe care of all
23 patients in a setting where census and acuity are dynamic.
- 24 2. Newborns (p48)
- 25 a. Staffing: Delivery of safe and effective perinatal nursing care requires
26 appropriately qualified registered nurses in adequate numbers to meet
27 the needs of each patient taking into account numerous factors such as
28 nursing experience, patient acuity, patient birthweight, patient
29 diagnoses, patient turn-over, and family educational needs (p30).
- 30 b. Staffing should be consistent with those found in national guidelines
31 such as the Association of Women’s Health, Obstetrical and Neonatal
32 Nurses (AHWONN) and the National Association of Neonatal Nurses
33 (NANN). (p30)
- 34 viii. The primary responder, physician or NP, managing care (“on call”) is be able to arrive
35 on site within 30 minutes. Nurse practitioners will function within their scope of
36 practice with physician collaboration.
- 37 ix. If the primary responder is covering more than one institution then appropriate back-
38 up coverage must be available, to enable an appropriate responder to be present at
39 each site within 30 minutes or less.
- 40 c. Physical requirements

- 1 i. Equipment for labor, delivery, newborn resuscitation, and newborn care should be
2 stored either in the room or in a nearby central storage or supply area and should be
3 immediately available to the labor, delivery, and recovery room.
 - 4 ii. All neonatal services in a birthing hospital have facilities available to perform the
5 following functions:
 - 6 1. Resuscitation and stabilization
 - 7 2. Admissions and observation
 - 8 3. Normal newborn care (in the newborn nursery or, ideally, in the mother's
9 room)
 - 10 4. Isolation
 - 11 5. Visitation
 - 12 6. Supporting service areas
 - 13 iii. The facility will have a resuscitation area that is within or in close proximity to the
14 patient labor and delivery area for timely and safe neonatal resuscitation. If
15 resuscitation takes place in the labor, delivery, and recovery room, the area should be
16 large enough to allow for proper resuscitation of the newborn without interference
17 with the care of the mother. Items contaminated with maternal blood, urine, and
18 stool should be kept physically distant from the neonatal resuscitation area. The
19 thermal environment for infant resuscitation should be maintained by use of an infant
20 warmer or overhead source of radiant heat. The World Health Organization
21 recommends that during delivery, room temperature be 25 C (77 F) or higher to
22 prevent hypothermia. (p42) When delivery of a preterm infant is anticipated, the
23 temperature of the room should be increased. (p46)
 - 24 iv. Resuscitation area compliant with state licensing regulations
 - 25 v. Admission and Observation (transitional and stabilization) area compliant with state
26 licensing regulations
 - 27 vi. Neonatal care units
 - 28 1. Within each perinatal care facility there may be several types of units for
29 newborn care. These units are defined by the content and complexity of care
30 required by a specific group of infants. As in the resuscitation and stabilization
31 area and the admission and observation area, equipment for emergency
32 resuscitation is required in all neonatal care areas. (p48)
 - 33 vii. Safety and Environmental Control – the facility should ensure that electrical safety,
34 temperature, humidity, air change and air conditioning meet national hospital safety
35 standards. There should be practices to ensure radiation safety for neonates, staff,
36 and family members. (P54)
 - 37 viii. Illumination – ambient light should be adjustable and meet national standards
38 regarding level of lighting for patients and staff. (p55)
- 39
- 40 d. Perinatal Service Plan

- 1 i. A hospital policy must describe criteria for maternal and neonatal consultation, and
2 criteria for maternal and neonatal transports, plans of care for mothers and neonates,
3 and support services to be provided
- 4 ii. Delineation of those neonates in which consultation with a neonatologist to
5 determine whether transport to a higher level of care is required. Indications for
6 consultation for conditions such as (but not limited to): small for gestational age (<
7 10th percentile), documented sepsis, seizures, congenital heart disease, multiple
8 congenital anomalies, apnea, respiratory distress, neonatal asphyxia, severe anemia,
9 or non-physiological hyperbilirubinemia.
- 10 iii. The hospital must have a formal transport policy delineating the transport process
11 and also (a) letter(s) of agreement(s) between the hospital and level II, level III, and/or
12 level IV facility(ies) to assure timely and safe transports
- 13 iv. There must be written criteria for continuing education for staff in neonatal and
14 maternity care including medical, nursing, and respiratory staff, with evidence of
15 annual competence assessment appropriate to the patient population served.
- 16 v. There must be participation in continuous quality improvement with documented
17 ongoing monitoring of outcomes, deliveries of VLBW infants, transports,
18 complications and action plans to improve any areas of concern. The continuous
19 quality improvement plan includes implementing strategies to maintain expertise and
20 competence in situations of limited clinical exposure; (eg this may include this may
21 include cross training and coordination with another facility.
- 22 vi. The level I hospital shall maintain a system of recording data including (but not limited
23 to) patient admissions, discharges, birth weight, outcome, complications, and
24 transports to meet the requirement of the state designation.
- 25 e. Examples of infants with problems that could be cared for in a Level I facility include
26 neonates ≥ 35 weeks and:
- 27 i. Stable infants receiving intravenous antibiotics
- 28 ii. Phototherapy for uncomplicated hyperbilirubinemia
- 29 iii. Routine hypoglycemia
- 30 iv. Routine feeding issues
- 31 v. Transient tachypnea of newborns without nasal CPAP or mechanical ventilation which
32 is improving
- 33
- 34
- 35

- 1 III. **Level II Neonatal care-** In addition to the baseline guidelines for Level I nurseries, Level II facilities
2 have the ability to care for ≥ 32 week gestation infants and birth weight ≥ 1500 grams who have
3 physiologic immaturity or who are moderately ill with problems that are expected to resolve
4 rapidly and are not anticipated to require subspecialty services on an urgent basis.
- 5 a. Capabilities of a level II facility-
- 6 i. All capabilities for Level I must be met
- 7 ii. Evaluate and provide care for infants who are ≥ 32 weeks gestation and birth weight
8 ≥ 1500 gram from birth until discharge
- 9 iii. If needed, the facility is able to provide CPAP or short term mechanical ventilation
10 (≤ 24 hours) or both including equipment, laboratory support for newborns, and
11 expertise: nursing, respiratory, physician, and other personnel (p12).
- 12 1. In facilities where the special care unit is the highest level of neonatal care,
13 equipment should be available to provide continuous positive airway pressure and, in
14 some units, equipment may be available to provide short-term (less than 24 hours)
15 assisted ventilation. (p49)
- 16 iv. Capability to stabilize infants born before 32 weeks' gestation and weighing less than
17 1500 g until transfer to a higher level neonatal ICU facility.
- 18 v. Services and capabilities of a level I facility plus:
- 19 1. Space designated for care of sick/convalescing neonates
- 20 2. Cardiorespiratory monitor for continuous observation
- 21 3. Peripheral IV insertion, maintenance and monitoring for fluids, glucose,
22 antibiotics
- 23 4. Neonatal blood gas monitoring
- 24 5. Umbilical or peripheral arterial catheter insertion, maintenance and
25 monitoring
- 26 6. Peripheral or central administration and monitoring of total parenteral
27 nutrition and/or medication and fluids
- 28 7. Oxygen delivery via nasal cannula
- 29 8. Nasal CPAP
- 30 9. Short term ventilation
- 31
- 32 vi. The hospital must have a policy regarding the timely evaluation of retinopathy of
33 prematurity (ROP) in the event that an infant at risk is present. Having access to an
34 ophthalmologist with expertise in retinopathy of prematurity is available to examine
35 the retinas of infants weighing less than 1500 g at birth, as well as selected infants
36 weighing 1,500-2,000 g at birth with an unstable clinical course and who are thought
37 to be at risk for ROP by their attending physician. High quality video imaged
38 telemedicine with appropriately trained personnel is permissible. (⁹ p. 354-355) An
39 organized program for the monitoring, treatment and follow-up of ROP is readily
40 available.^{8 11}

1 b. Health Care Providers of Neonates-

- 2 i. Level I health care providers plus: Pediatric hospitalists, neonatologists, and neonatal
3 nurse practitioners (NNP) as appropriate.
- 4 ii. The medical director of a level II newborn facility, who should be a board
5 eligible/certified neonatologist, shall have an active role and responsibility in the
6 organization, oversight, and monitoring of personnel, process, and quality.
- 7 iii. The facility has specialized physicians, or neonatal nurse practitioners, and/or
8 specialized support personnel (eg, respiratory therapists, radiology technicians, and
9 laboratory technicians) and equipment (eg, portable chest radiographs and blood gas
10 laboratory) continuously available to provide ongoing care as well as to address
11 emergencies. When an infant is on a ventilator, these specialized personnel should be
12 continually available on site to manage respiratory emergencies. (9p. 25, 32)
13 Neonatal nurse practitioners shall function within their scope of practice with
14 physician collaboration.
- 15 iv. The nurse manager besides level I criteria would preferably have a BSN degree or
16 higher
- 17 v. Staffing should be consistent with those found in national guidelines such as the
18 Association of Women’s Health, Obstetrical and Neonatal Nurses (AHWONN) and the
19 National Association of Neonatal Nurses (NANN). (p30)
- 20 vi. A registered dietician with pediatric knowledge shall be available (p35)
- 21 vii. At least one MSW with relevant experience, and at least one nurse educator with
22 appropriate training in special care nursery or perinatal care to coordinate staff
23 education and development.
- 24 viii. When CPAP in use, there shall be in-house and immediately available respiratory
25 therapist with documented competence and experience in the management of
26 neonates with cardiopulmonary disease
- 27 ix. Personnel experienced in airway management and the diagnosis and treatment of
28 pneumothorax shall be readily available
- 29 x. In units where neonates receive mechanical ventilation, medical, nursing, or
30 respiratory staff with demonstrated ability to intubate the trachea, manage assisted
31 ventilation, and decompress pneumothorax shall be available continually. (p32)
- 32 xi. Radiologist(s) on-staff with daily availability who can interpret neonatal studies such
33 as chest and abdominal radiographs, and cranial ultrasounds
- 34 xii. Experienced blood bank technicians shall be immediately available in the hospital for
35 blood banking procedures and identification of irregular antibodies. Blood
36 component therapy shall be readily available.
- 37 xiii. The infant’s primary care physicians should provide medical follow-up and referral of
38 high risk infants with abnormal or delayed neurodevelopmental progress. (p. 376-77)
- 39 xiv. The primary responder, physician or NNP, managing care (“on call”) should be able to
40 arrive on site within 30 minutes or less.

- xv. If the primary responder is covering more than one institution then appropriate back-up coverage is available and able to arrive at each site within 30 minutes or less.
- xvi. The facility has the capability of stabilizing ill infants or those born less than 32 weeks including unexpectedly small or sick neonates prior to transfer to a higher level facility, following thermoregulation and resuscitation guidelines per AHA Guidelines for Neonatal Resuscitation and stabilization pending transfer to appropriate level of care facility based on neonatal services required.
- xvii. Arrange transfers to a higher level of care in conjunction with their written guidelines and transfer agreements

c. Physical layout

- i. Sick neonates who do not require intensive care but who require 6-12 hours of nursing care each day should be cared for in a special care nursery. A special care unit also may be used for convalescing neonates who have returned to specialty facilities from an intensive care unit in an outside facility or have been transferred from a higher level of care within the institution. The special care area may be separate from, adjacent to, or combined with a level III or level IV NICU in hospitals where these exist.
- ii. The neonatal special care area is optimally close to the delivery area, cesarean delivery room, and the intensive care area (if there is one in the same facility) and away from general hospital traffic. It should have radiant heaters or incubators for maintaining body temperature, as well as infusion pumps, cardiopulmonary monitors, and oximeters.(p49)

d. Perinatal Service Plan

- i. A hospital policy will describe criteria for maternal and neonatal consultation, and criteria for maternal and neonatal transports, standards of care for mothers and neonates, and support services to be provided
- ii. Delineation of those neonates in which consultation with a neonatologist to determine whether transport to a higher level of care is required. Consultation should describe conditions such as (but not limited to): birth weight < 1500 g, 10 min apgar of 5 or less, handicapping condition or developmental disabilities that threaten subsequent development in an otherwise stable infant.
- iii. A formal transport policy is required that describes the process for timely and safe transport. Formal letter(s) of agreement(s) between the hospital and level III or IV facility(ies) for transports required. Some criteria for transport include: premature infant < 32 weeks, birth weight < 1500 g, assisted ventilation that is anticipated to exceed 24 hours, congenital heart disease associated with cyanosis, congestive heart failure or impaired peripheral blood flow, major congenital malformations requiring immediate comprehensive evaluation or neonatal surgery; neonatal surgery requiring anesthesia, sepsis unresponsive to therapy, associated with persistent shock or other

- 1 organ system failure, uncontrolled seizures, stupor, coma or hypoxic ischemic
2 encephalopathy; or metabolic derangements persisting after initial therapy.
- 3 iv. Criteria for continuing education for staff in neonatal and maternity care including
4 medical, nursing, and respiratory staff, with evidence of annual competence
5 assessment appropriate to the patient population served.
- 6 v. Participation in continuous quality improvement. The continuous quality
7 improvement plan includes implementing strategies to maintain expertise and
8 competence in situations of limited clinical exposure; (eg, this may include cross
9 training and coordination with another facility).
- 10 vi. The level II hospital shall maintain but not limited to a system of recording patient
11 admissions, discharges, birth weight, outcome, complications, and transports to meet
12 the requirement of the hospital designation process.
- 13
- 14 e. Examples of ≥ 32 week gestation infants and birth weight ≥ 1500 grams that could be cared for
15 at a Level II nursery include:
- 16 i. Infants with signs of mild sepsis (normal organ perfusion) receiving antibiotics
17 ii. Infants with respiratory issues requiring supplemental oxygen by hood or nasal
18 cannula or nasal CPAP
19 iii. Infants that require continuous positive airway pressure (CPAP) or short term
20 mechanical ventilation (anticipated < 24 hours)
21 iv. Infants with minor anomalies that can be discharged to home without intervention
22 v. Infants with known lethal anomalies where a birth plan and subsequent care is agreed
23 upon by parents and physicians.
24 vi. Infants of all gestational ages and weights convalescing after intensive care (home or
25 reverse transfers) if care needs can be met
26
27

- 1 IV. **Level III Neonatal Care-** In addition to meeting the guidelines for Level I and II neonatal care,
2 Level III facilities have the ability to care for infants of any gestational age with routine to
3 complex medical problems. These hospitals should facilitate transport and provide outreach
4 education to other hospitals and the community.
- 5 a. Capabilities- (⁹p15)
- 6 i. Provide comprehensive care for Infants of all gestational ages with mild to critical
7 illnesses
- 8 ii. Provide sustained life support which may include conventional ventilation, high-
9 frequency ventilation, and/or inhaled nitric oxide.
- 10 iii. The facility will ensure that a transport team will be readily available to facilitate
11 transfer of infants to this facility or do “home” transfers. The transport team may be
12 contracted through a third party transport service.
- 13 iv. Provide level I and II care plus able to provide:
- 14 1. The full range of respiratory support that shall include conventional and/or
15 high frequency mechanical ventilation and/or inhaled nitric oxide (p12)
- 16 2. Advanced imaging with interpretation on an urgent basis, including computed
17 tomography, magnetic resonance imaging, and echocardiography and cranial
18 ultrasound (p12)
- 19 3. Pediatric echocardiography with written protocols for pediatric cardiology
20 interpretation and consultation at the site or by prearranged consultative
21 agreement
- 22 4. A mechanism for infants at high risk for neurodevelopmental, medical, or
23 psychosocial complications for follow up care at discharge.
- 24 5. Quality improvement program including collecting data to assess outcomes
25 within their facility and to compare with national outcomes. (p15)
- 26 6. Arrangements for perinatal pathology services
- 27 7. Prompt and readily available access to a full range of pediatric medical
28 subspecialists and pediatric surgical specialists on site or at a closely related
29 institution by prearranged consultative agreement (p12, 25-26)
- 30
- 31
- 32 b. Health Care Providers of Neonates-
- 33 i. The medical director should be a board eligible/ certified neonatologist.
- 34 ii. A neonatologist should be continuously available for consultation 24 hours per day, 7
35 days per week, and able to arrive on site within 30 minutes or less. (⁹p26) If the
36 neonatologist is covering two institutions, then a back-up neonatologist is available
37 and able to arrive on site within 30 minutes.
- 38 iii. Personnel qualified to manage the care of mothers or infants with complex or critical
39 illnesses, including emergencies, should be in-house. (⁹p 26). There must be the
40 immediate availability of neonatologist, pediatric hospitalist, or neonatal nurse

1 practitioner with demonstrated competence in management of severely ill neonates,
2 including those requiring mechanical ventilation.

- 3 iv. Level III NICUs require urgent access for consultation to a broad range of pediatric,
4 rather than adult, medical subspecialists, (eg, pediatric cardiology, pediatric
5 neurology, pediatric hematology, genetics, pediatric nephrology, metabolism,
6 pediatric endocrinology, pediatric gastroenterology-nutrition, pediatric infectious
7 diseases, pediatric pulmonology, immunology, pediatric pathology, and pediatric
8 pharmacology. (pp12, 26) Level III units should have the capability to perform major
9 surgery (including pediatric surgical and pediatric anesthesia capability) onsite or at a
10 closely related institution by prearranged consultative agreements, ideally in
11 geographic proximity. Prearranged consultative agreements can be performed using
12 telemedicine technology, or telephone consultation, or both from a distant location. ⁸
13 (⁹p. 15, 26)
- 14 v. Level III NICUs without the full range of pediatric subspecialists and/or surgeons with
15 pediatric expertise should be closely aligned with a level III or level IV NICU that
16 provides pediatric surgical and pediatric subspecialty support that is not available in
17 their vicinity. These NICUs should collaborate with the most appropriate
18 comprehensive level III/IV NICU for consultation and timing of transfers. Outcomes
19 should be monitored by quality improvement processes to ensure appropriate
20 referral and timely transfer.
- 21 vi. If geographic constraints for land transportation exist, the level III facility shall ensure
22 availability of rotor and fixed wing transport services. (p15)
- 23 vii. At least one registered dietician who has special training in neonatal/perinatal
24 nutrition and can plan diets that meet special needs of high risk mothers and
25 neonates
- 26 viii. At least one occupational or physical therapist with neonatal experience (p35)
- 27 ix. At least one individual skilled in evaluation and management of neonatal feeding and
28 swallowing disorders (eg, speech-language pathologist) is available
- 29 x. Qualified personnel for support services such as diagnostic laboratory studies,
30 radiological studies, and ultrasound examinations available 24 hours/day and 7
31 days/wk
- 32 xi. Respiratory therapists who can supervise the assisted ventilation of neonates; RCP
33 skilled in neonatal airway management immediately available for every high risk
34 delivery
- 35 xii. Pharmacy personnel with pediatric expertise who can work to continually review their
36 systems and processes of medication administration to ensure that patient care
37 policies are maintained. (p35)
- 38 xiii. Nurse educator: an educator with relevant graduate education is preferred for staff
39 development and to effect system wide changes to improve program of care

- 1 xiv. The nurse manager shall have a minimum of a BSN degree with an advanced degree
2 preferred. Also, nurses should be able to provide care for infants requiring high
3 frequency ventilation and/or inhaled nitric oxide as well as care for chronically
4 technologically dependent infant. (p33)
- 5 xv. The number of nursing, medical, and surgical personnel required in the neonatal
6 intensive care area is greater than that required in less acute perinatal care areas.
7 Staffing should be consistent with those found in national guidelines such as the
8 Association of Women’s Health, Obstetrical and Neonatal Nurses (AHWONN) and the
9 National Association of Neonatal Nurses (NANN). (p30)
- 10 xvi. In some cases, such as during extracorporeal life support, additional nursing
11 personnel are required. In addition, the amount and complexity of equipment
12 required also are considerably greater.
- 13 xvii. MSW: At least one full time licensed MSW (for every 30 neonatal beds in a facility to
14 include term nursery, step-down, and NICU beds) who has experience with
15 socioeconomic and psychosocial problems of high risk mothers and fetuses, ill
16 neonates, and their families. Pastoral care available
- 17 xviii. An ophthalmologist with expertise in retinopathy of prematurity should examine the
18 retinas of all infants born at 30 weeks of gestation or less or weighing less than 1500 g
19 at birth, as well as selected infants weighing 1,500-2,000 g at birth with an unstable
20 clinical course and who are thought to be at risk by their attending physician.
21 Examination may be via high quality video telemedicine by appropriately trained
22 personnel. (9 p. 354-355) An organized program for the monitoring, treatment and
23 follow-up of ROP should be readily available.^{8 12}

24 c. Physical facility

- 25 i. Constant nursing and continuous cardiopulmonary and other support for severely ill
26 newborns should be provided in the intensive care unit. Because emergency care is
27 provided in this area, laboratory and radiologic services should be readily available 24
28 hours per day. The results of blood gas should be available shortly after sample
29 collection. In many centers, a laboratory adjacent to the intensive care unit provides
30 this service.
- 31 ii. The neonatal intensive care area should ideally be located near the delivery area and
32 cesarean delivery room(s) and should be easily accessible from the hospital’s
33 ambulance entrance. It should be located away from routine hospital traffic. Intensive
34 care may be provided in individual patient rooms, in a single area, or in two or more
35 separate rooms.
- 36 iii. Equipment and supplies in the intensive-care area should include all those needed in
37 the resuscitation and intermediate-care areas. Immediate availability of emergency
38 oxygen is essential. In addition, equipment for long-term ventilator support should be
39 provided. Ventilators should be equipped with nebulizers or humidifiers with heaters.
40 Equipment for manual-assisted ventilation, including appropriately sized face masks

1 and flow-inflating or self-inflating bags should be available at each bed space.
2 Continuous monitoring of oxygen concentrations, body temperature, heart rate,
3 respiration, oxygen saturation, and blood pressure measurements should be available
4 for each patient. Supplies should be kept close to the patient bed space so that nurses
5 are not away from the neonate unnecessarily and may use their time and skills
6 efficiently. A central modular supply system can enhance efficiency.

- 7 iv. In some cases, certain surgical procedures (eg, ligation of a patent ductus arteriosus)
8 are performed in an area in or adjacent to the NICU. Specific policies should address
9 preparatory cleaning, physical preparation of the unit, presence of other newborns
10 and staff, venting of volatile anesthetics, and quality procedures, should be
11 comparable to those required for similar procedures in the surgical department of the
12 hospital.
- 13 v. Support service areas (already found in hospital licensing regulations).
- 14 d. High Risk Followup care- The facility shall have a mechanism for follow-up care of high risk
15 neonatal subgroups.(p376-77)
- 16 e. TRANSPORT
 - 17 i. The Director of transport program is a board eligible/certified neonatologist or in
18 selected circumstances a pediatrician with special expertise in neonatology. The
19 responsibilities include (p81-82):
 - 20 a. Training and supervising staff
 - 21 b. Ensuring appropriate review of all transport records
 - 22 c. Developing and implementing protocols for patient care
 - 23 d. Developing and maintaining standardized patient records and a
24 database to track the program
 - 25 e. Establishing a program for performance quality
 - 26 f. Identifying trends and effecting improvements in the transport system
27 by regularly reviewing operational aspects of the program and
28 evaluation forms from both the referring and receiving hospitals soon
29 after each transport
 - 30 g. Developing protocols for programs that use multiple modes of
31 transport
 - 32 h. Determining which mode of transport which should be used and any
33 conditions such as weather that would preclude the use of a particular
34 mode of transport
 - 35 i. Developing alternative plans for care of the patient if a transport
36 cannot be accomplished
 - 37 j. Ensuring that proper safety standards are following during transport
 - 38 k. Requiring the transport services to follow established guidelines
39 regarding maintenance and safety

- 1 2. Facilities that have therapeutic hypothermia (head and/or body cooling)
2 capability should be identified (This is not a requirement for level III NICU)
3

4 f. Perinatal Service Plan

- 5 i. A hospital policy will describe criteria for maternal and neonatal consultation, and
6 criteria for maternal and neonatal transports, plans of care for mothers and neonates,
7 and support services to be provided
8 ii. Delineation of those neonates in which consultation to determine whether transport
9 to a higher level of care is required. Consultation should describe conditions such as
10 (but not limited to): complex congenital anomaly requiring surgical correction,
11 hypoxic ischemic encephalopathy if head/body cooling capability does not exist at the
12 facility, or complex cardiac anomaly.
13 iii. There should be (a) letter(s) of agreement(s) between the hospital and other level
14 III/IV facilities for transports. Some criteria for transport include: congenital heart
15 disease associated with cyanosis, congestive heart failure or impaired peripheral
16 blood flow, major congenital malformations requiring immediate comprehensive
17 evaluation or neonatal surgery; neonatal surgery requiring specialized anesthesia,
18 hypoxic ischemic encephalopathy or complex medical conditions (eg, chronic lung
19 disease, “short gut” with cholestasis).
20 iv. Criteria for continuing education for staff in neonatal and maternity care including
21 medical, nursing, and respiratory staff, with evidence of annual competence
22 assessment appropriate to the patient population served.
23 v. Participation in continuous quality improvement. The continuous quality
24 improvement plan includes implementing strategies to maintain expertise and
25 competence in situations of limited clinical exposure; (eg, this may include cross
26 training and coordination with another facility.
27 vi. The level III hospital shall maintain a system of recording patient admissions,
28 discharges, birth weight, outcomes, complications, and transports to meet the
29 requirement of the hospital designation process.
30

31 g. Examples of infants cared for at a Level III NICU could include:

- 32 i. Infants of all gestational ages
33 ii. Infants with congenital anomalies within the scope of practice of the subspecialists at
34 that institution
35 iii. Infants with hypoxic-ischemic encephalopathy meeting criteria for hypothermia
36 treatment if the institution has experience in instituting and monitoring this therapy.
37 (°p. 324)
38 iv. Infants with known lethal anomalies

1 **Level IV Neonatal Care** - In addition to the guidelines for Levels I-III, Level IV facilities have the ability to
2 care for infants with very complex medical problems and are capable of providing surgical repair of
3 complex congenital or acquired conditions (eg, congenital cardiac malformations that require
4 cardiopulmonary bypass with or without extracorporeal oxygenation). These hospitals should facilitate
5 transport and provide outreach education to the community and/or outlying hospitals.

6 h. Capabilities-

- 7 i. Infants of all gestational ages with mild to critical illnesses.
- 8 ii. Infants with complex congenital or acquired conditions that require surgical
9 correction (eg, congenital cardiac malformations that require cardiopulmonary bypass
10 with or without extracorporeal membrane oxygenation. (⁹p16) ¹²

11 i. Health Care Providers of Neonates-

- 12 i. The personnel required includes those at level III and pediatric surgical subspecialists
- 13 ii. The medical director should be a board eligible/certified neonatologist. (⁹ p25)
- 14 iii. A neonatologist is available on site 24 hours per day.
- 15 iv. Nurse educator: a clinical education specialist with graduate education is preferred for
16 staff development and to effect system wide changes to improve program of care
- 17 v. The nurse manager should have an advanced degree
- 18 vi. These facilities should have a wide range of pediatric medical subspecialists and
19 pediatric surgical subspecialists available to do inpatient consults urgently 24 hours
20 per day, 7 days per week, as needed.
- 21 vii. Maintain a full range of pediatric medical subspecialists, pediatric surgical
22 subspecialists, and pediatric anesthesiologists at the site
 - 23 1. Pediatric Surgical Subspecialists include a full range (but not necessarily all):
24 Pediatric ENT surgeons, Pediatric GI surgeons, Pediatric neurosurgeons,
25 Pediatric Urological surgeons, Pediatric Cardiothoracic surgeons, Pediatric
26 Ophthalmology, Pediatric Orthopedic Surgery
 - 27 2. Pediatric medical subspecialists should encompass a full range (but not
28 necessarily all): Pediatric cardiology, Pediatric endocrinology, Pediatric
29 gastroenterology, Pediatric geneticist, Pediatric hematologist, Pediatric
30 immunologist, Pediatric infectious disease, Pediatric Metabolism, Pediatric
31 nephrology, pediatric neurology, Pediatric oncology, Pediatric Pharmacology,
32 Pediatric pulmonary, Pediatric radiology, and Pediatric rheumatology
 - 33 3. Support personnel, infrastructure, equipment and capability to manage
34 neonates with complex congenital malformations (eg, cardiac congenital or
35 acquired anomalies requiring surgery, omphaloceles or gastroschisis,
36 diaphragmatic hernias, neurological disorders requiring surgery, or
37 genitourinary conditions requiring surgery).
- 38 viii. Physicians and staff have expertise to care for newborn infants with complex
39 congenital malformations.

40 j. High Risk Followup Care- The facility has a mechanism for follow-up care of high risk neonatal
41 subgroups.(p376-77)

1 k. Perinatal Service Plan

- 2 i. A hospital policy shall describe criteria for maternal and neonatal consultation, and
3 criteria for maternal and neonatal transports, plans of care for mothers and neonates,
4 and support services to be provided
- 5 ii. Delineation of those neonates in which consultation to determine whether transport
6 to a different facility is appropriate (eg, if cardiac surgery is not performed at the
7 facility).
- 8 iii. A letter of agreement between the hospital and a different facility for transports
- 9 iv. Criteria for continuing education for staff in neonatal and maternity care including
10 medical, nursing, and respiratory staff, with evidence of annual competence
11 assessment appropriate to the patient population served.
- 12 v. Participation in continuous quality improvement
- 13 vi. The level IV hospital shall maintain a system of recording patient admissions,
14 discharges, birth weight, outcome, complications, and transports to meet the
15 requirement of the state designation process.

16 l. Examples of infants cared for at a Level IV NICU could include:

- 17 i. All infants of any gestational age
- 18 ii. Infants with severe respiratory failure
- 19 iii. Infants requiring extracorporeal membrane oxygenation (ECMO)¹³
- 20 iv. Infants with complex medical conditions
- 21 v. Infants with congenital lesions (eg, complex cardiac conditions) that require surgical
22 repair

23

24 V. **Quality Improvement, Data Collection and Reporting-** Excellent outcomes for mother and baby
25 are the ultimate goal of these guidelines. Data on outcomes will be crucial in determining the
26 impact of these recommendations on care throughout the State. Therefore, we recommend a
27 minimum amount of data should be collected that is based on nationally recognized definitions
28 and submitted every 6 months to the state. Ongoing CQI efforts with appropriate
29 documentation of such activities and progress is required. Each facility shall collect the following
30 data and submit outcome data as specified by the state

31

32 VI. TRANSFERS

- 33 a. Each facility shall have formal written transfer protocols to optimize the safe and timely
34 transfer of the neonate to a higher level of care, including formal written agreements with
35 hospitals having higher levels of care.
- 36 i. The receiving hospital must have space and qualified personnel to treat the patient
37 and must have agreed to accept the transfer. A hospital with level II or level III
38 specialized capabilities, may not refuse to accept patients if space is available.
- 39 ii. The transferring hospital must minimize the risks to the patient's health, and the
40 transfer must be executed through the use of qualified personnel and transportation
41 equipment.

- 1 iii. The transferring hospital must send to the receiving hospital all medical records
2 related to the emergency condition that are available at the time of transfer.(p516-
3 517)
- 4 iv. Each facility (Levels I-IV) must appoint a director of transport to oversee their
5 processes, develop protocols, review the transfer processes, and perform quality
6 improvement.

7 IX. Regions and Regional Advisory Council (see attached)

8
9 ----END OF STANDARDS----

10
11 FURTHER RECOMMENDATIONS

- 12
- 13 b. **HOME FACILITY or REVERSE TRANSFERS-** The Perinatal Advisory Council strongly
14 recommends payment to the home institution and for transfers of convalescing infants to
15 appropriate centers closer to home, such as back transfers or home transfers once the
16 neonate’s condition is stabilized the higher level of care is no longer needed. Optimizing
17 maternal-infant bonding and breast-feeding such as transport of multiples or postpartum
18 patient to the higher level of NICU facility should be considered.

- 19
- 20 VII. **EQUITABLE PAYMENT FOR SERVICES** – The Perinatal Advisory Council strongly recommends that
21 payment be equal for the same level of service rendered, regardless of the type of facility,
22 assuming the facility is designated to be able to care for patient. For example, the payment for
23 medical services related to caring for an infant at 33 weeks (level II care) should be the same
24 whether the neonate is in a level II, level III, or level IV facility.

- 25
- 26 VIII. **INCENTIVES FOR QUALITY** – The Perinatal Advisory Council strongly recommends that financial
27 incentives be provided for high quality of care, and not simply for services. For example, a level I
28 or level II neonatal facility that has a very low rate of VLBW births at their institution due to
29 appropriate transfer of their high risk pregnant patients to the correct facility (level III/IV) should
30 be rewarded for good quality. Currently, the obstetrician and hospital is incentivized financially
31 to deliver those higher risk patients at their institution with neonatal transfer after birth.

32
33
34
35 **OUTCOMES (specified list not in rules)**

- 36 IX. (outcomes subcommittee to continue work on this):

- 1 a. All hospitals: **(THIS NEEDS MORE WORK BY THE OUTCOMES SUBCOMMITTEE)**
- 2 i. Deliveries by day, month and year- number
- 3 ii. Vaginal, vaginal operative, and cesarean deliveries- number
- 4 iii. Unintended out of hospital deliveries- number
- 5 iv. Inductions <39 weeks without medical indication- number
- 6 v. Births by completed week of gestational age- number
- 7 vi. Birth weight in kilograms- mean
- 8 vii. VLBW infants (less than 1500 g) born in a level I or II facility
- 9 viii. ELBW infants (less than 1000 g) born in a level I or II facility
- 10 ix. Antenatal steroids prior to delivery- 24w0d-33w6d of gestation (percentage per all
- 11 deliveries 24w0d-33w6d)
- 12 x. Mortality- Report for infants $\geq 22\ 0/7$ weeks gestation- number
- 13 1. Infants who died prior to transfer with and without lethal anomalies
- 14 2. Infants who died after transfer with and without lethal anomalies
- 15 3. Infants who died In the delivery room
- 16 4. Infants who died at ≤ 12 hours of age
- 17 5. Infants who died after 12 hours of age
- 18 6. Intrapartum stillbirths
- 19 xi. Maternal transfers to higher level of care- number
- 20 xii. Neonatal transfers to higher level of care – number
- 21 xiii. Indicated maternal transfers (based on hospital policy) that did not occur – number
- 22 xiv. Indicated neonatal transfers (based on hospital policy) that did not occur - number
- 23 xv. Back transfers to closer community nursery (home)- number
- 24 xvi. Admission temperature within one hour of birth- number within 36-37°
- 25 xvii. Length of stay-
- 26 1. Vaginal delivery infants- mean in days
- 27 2. Cesarean delivery infants- mean in days
- 28 xviii. Readmissions for jaundice, dehydration, feeding difficulties
- 29 xix. Rate of meconium aspiration affecting infants
- 30 xx. Breastfeeding-
- 31 1. Number receiving only breast milk at discharge
- 32 2. Number receiving only formula at discharge
- 33 3. Number receiving breast milk and formula at discharge
- 34 xxi. Readmissions to hospital < 7 days of discharge- number
- 35 b. Level II-IV facilities- Examples of outcomes to be reported include (not limited to):
- 36 i. **Ideally, level II-IV facilities would participate in a preexisting network with**
- 37 **meaningful outcome data such as the Vermont Oxford Network (VON)**
- 38 ii. **Outcomes**
- 39 1. Chronic lung disease- number of infants <33 weeks
- 40 2. Pneumothorax- number of infants

- 1 3. Nosocomial infection- number of infections
- 2 4. Central line associated bacterial infection- number of infections
- 3 5. Ventilator associated pneumonia (VAP) - number
- 4 6. Grade III or IV intraventricular hemorrhage- number of infants
- 5 7. Retinopathy of prematurity requiring intervention- number of infants
- 6 8. Necrotizing enterocolitis \geq Stage 2- number of infants
- 7 9. Length of stay- mean in days
- 8 10. Infants discharged to home
- 9 11. Infants transferred to higher level of care
- 10 12. Infants who died
- 11 13. Total of all admissions to NICU and intermediate care
- 12 14. Number of transfers to the hospital
- 13 15. Number of back (home) transfers
- 14 c. Level IV facilities- Examples of outcomes to be reported include (but not limited to):
- 15 i. Infants placed on ECMO for respiratory failure
- 16 ii. Infants receiving cardiac surgery <28 days of age (excluding PDA ligations)

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- ¹ Wise PH. Neonatal health-care policy: Promise and Perils of Reform. *Neoreviews* 2010;11:e12
- ² Rogowski JA, Staiger DO, Horbar JD. Variations in the quality of care for very-low-birthweight infants: implications for policy. *Health Affairs* 2004;23(5):88-97
- ³ Grzybowski S, Stoll K, Kornelsen J. Distance matters: a population based study examining access to maternity services for rural women. *BMC Health Services Research* 2011;11:147
- ⁴ Hemminki E, Heino A, Gissler M. Should births be centralized in higher level hospitals? Experiences from regionalized health care in Finland. *BJOG* 2011;118-1195
- ⁵ Snowden JM, Cheng YW, Kontgis CP, Caughey AB. The association between hospital obstetric volume and perinatal outcomes in California. *Am J Obstet Gynecol* 2012;207:478.e1-7
- ⁶ Lorch SA, Baiocchi M, Ahlberg CE, Small DS. The differential impact of delivery hospital on the outcomes of premature infants. *Pediatrics* 2012;130:270-278
- ⁷ Laswell SM, Barfield WD, Rochat RW, Blackmon L. Perinatal regionalization for very low-brth-weight and very preterm infants. *JAMA* 2010;304(9):992-1000
- ⁸ American Academy of Pediatrics Committee on Fetus and Newborn. Policy Statement on Levels of Neonatal Care. *Pediatrics* 2012;130:587-597
- ⁹ American Academy of Pediatrics and The American College of Obstetricians and Gynecologists. Guidelines for Perinatal Care, Seventh Edition. 2012.
- ¹⁰ American Academy of Pediatrics Committee on Fetus and Newborn. Levels of Neonatal Care Policy Statement. *Pediatrics* 2004;114:1341-1347
- ¹¹ American Academy of Pediatrics, American Academy of Ophthalmology, American Association for Pediatric Ophthalmology and Strabismus and American Association of Certified Orthoptists. Screening Examination of Premature Infants for Retinopathy of Prematurity. *Pediatrics* 2013;131:189-195
- ¹² American Academy of Pediatrics Section on Cardiology and Cardiac Surgery. Guidelines for Pediatric Cardiovascular Centers. *Pediatrics* 2002;109:544-549
- ¹³ <http://www.elsonet.org/index.php/resources/guidelines.html>

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Policy Council for Children and Families		
Number of Members:	18 voting and 6 ex officio		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	Est. 7/1/2016	Date to Be Abolished:	7/1/2020
Budget Strategy (Strategies) (e.g. 1-2-4)	A.1.1	Strategy Title (e.g. Occupational Licensing)	Children with Special Needs
Budget Strategy (Strategies)	A.1.1	Strategy Title	Strategic Engagement

State / Federal Authority
 State Authority
 State Authority

 State Authority
 Federal Authority
 Federal Authority
 Federal Authority

Select Type	Identify Specific Citation
Statute	Texas Government Code §531.012
Admin Code	§351.815 (Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$7,000
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$7,000

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$28,000
Number of FTEs	0.0	0.0	0.40
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$28,000

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$7,000
758 - GR Match for Medicaid	\$0	\$0	\$28,000
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	0	0	4
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Committee Description: The Policy Council works to improve the coordination, quality, efficiency, and outcomes of services provided to children with disabilities and their families through the state's health, education, and human services systems. The Policy Council essentially acts as a voice of parents and families in providing input to state programs serving children with disabilities and special needs. The Policy Council for Children and Families will succeed and build on previous work by the Children's Policy Council, which will cease activity at the end of Fiscal Year 2016.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. This new committee does not yet have bylaws and has not yet met.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings? The committee is expected to meet four times each year at the HHSC Brown Heatly Public Hearing Room in Austin Texas.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

The Policy Council will submit a biennial policy report to the Legislature and Executive Commissioner that describes gaps and barriers to the provision of services to children with disabilities and their families and provides recommendations consistent with the Policy Council's purposes. The Policy Council may also engage in other deliverables and activities consistent with its purposes.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

This is a new committee. A previous, similar committee (Children's Policy Council) has provided input to state policy makers since 2001 and will release its final report in September 2016. Recommendations adopted by the Children's Policy Council in its most recent report published in September 2014 focused on improving access by disabled children to mental health services, notably by expanding the Youth Empowerment (YES) waiver, promoting the integration of mental health with primary care, and improving coordination within a fragmented care delivery system; providing comprehensive service coordination, adequate networks, enrollment in patient centered medical homes, early and ongoing outreach, and oversight and accountability in the STAR Kids program; expanding access to the Medically Dependent Children's Program; improving criteria used to authorize skilled nursing services; increasing reimbursement rates for Baclofen pumps; and supporting Texas efforts to become an Employment First State in preparing children with disabilities for their transition from school to college or work.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

The committee has not yet met; however, staff estimate that it will provide logistical support, facilitation, and documentation for all meetings; perform research and coordinate/produce analytics on behalf of the committee; coordinate planning discussions via webinar, in-person, or teleconference involving subject matter experts and work group leads; draft policy and related reports; manage/coordinate other deliverables originated by the committee; and meet with stakeholders to discuss and present goals, activities, accomplishments, policy issues, and future directions related to the committee. Staff will also coordinate the recruitment of members.

6. Have there been instances where the committee was unable to meet because a quorum was not present? No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. This new committee has not yet met.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meetings will be open to the public and opportunities for public comment will be provided for each meeting topic and at a designated time during each meeting. The public may also submit comments in writing to staff supporting the committee. Meetings will offer opportunities for stakeholders to provide invited presentations and serve as subject matter experts. Notices for meetings and other key milestones will be distributed to stakeholders via a program distribution list. Meetings will also be posted to the Texas Register in compliance with Texas Open

7b. Do members of the public attend at least 50 percent of all committee meetings? Yes

7c. Are there instances where no members of the public attended meetings? No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texans Care for Children, Coalition of Texans with Disabilities, East Texas Center for Independent Living, Texas Association for Home Care and Hospice, Texas Parent to Parent, and Texas Council for Developmental Disabilities.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals? Yes

9b. Please describe the rationale for this opinion.

This is a new committee. A previous, similar committee has a long history of active involvement in the development of policy of interest to families with children who have a disability.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Without this committee, the Health and Human Services System would not have a consistent source of comprehensive feedback, primarily from parents of children who have disabilities or special needs.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

None

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: STAR Kids Managed Care Advisory Committee

Number of Members: 21

Committee Status (Ongoing or Inactive): Ongoing Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 9/1/2013 **Date to Be Abolished:** 11/1/2017

Budget Strategy (Strategies) (e.g. 1-2-4)

Budget Strategy (Strategies)	Strategy Title (e.g. Occupational Licensing)	
	Strategy Title	

[State / Federal Authority](#)
[State Authority](#)
[State Authority](#)

[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Select Type	Identify Specific Citation
Statute	Government Code Sec. 533.00254
Admin Code	Sec. 351.833 (Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	0	0	0
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Committee Description: The STAR Kids Managed Care Advisory Committee is established to advise the commission on the establishment and implementation of the STAR Kids managed care program. STAR Kids does not have an appropriated funds for travel reimbursement; therefore no budget for this committee is indicated.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

The statute that requires implementation of STAR Kids also requires HHSC to consult with this advisory committee.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

None. As noted above, this committee serves a specific, time-limited function and does it well.

AGENDA:

STAR Kids Managed Care Advisory Committee

February 26, 2015

9 a.m. to 12:30 p.m.

Meeting Site:

Health and Human Services Commission
Brown-Heatly Building
Public Hearing Room
4900 North Lamar Blvd.
Austin, TX 78751

1. Welcome and Opening Remarks
Tucker welcomed members to the 6th meeting of the committee. Noted this is webcast. Sign up cards for public testimony. Limit comments to 3 minutes. Written comments submitted after meeting to starkids@hhsc.state.tx.us. Today looking at medically dependent childrens program. ____children. Also talking about _____ rolling into Medicaid December 2016. Asked members to make introductions.
 - a. Member introductions
 1. Elizabeth Tucker, Every child
 2. Brian Dees, HHSC
 3. Denise Sonleiter, family rep
 4. Rosalba Calleros
 5. Ernest Buck
 6. Angela Trahan, United, Mom
 7. Christopher Born, TX children's helath plan, Medicaid Chip contract
 8. David Reimer, Epic health services
 9. Tara Hopkins, Dentaquest
 10. Blake
 11. Holly Munin
 12. Stacey Mather, TX physical therapy
 13. Rahel Berhane
 14. John Calhoun
 15. Angela Trahan (Tan sweater, back to me)
 16. Kellie Dees
 17. Brad Fuhrman (Gray)
 18. Catherine Carlton, mom
 19. Victoria Walsh
 20. Blake Smith (goatee)
 21. Reiner (corner brown hair)
 22. Ernest Buck (turtle neck)
 23. Tara Hopkins
 24. Michelle Erwin
 25. Stacey Mather
 26. Laurie Vanhoose
 - b. Adopt meeting minutes from December 3, 2014
2. Health and Human Services Commission (HHSC) Updates
 - a. STAR Kids Updates

1. Turned over to Brian Dees, Office of Policy
 2. Nearing end of the process. Significant progress. May not have much to report at next meeting in June. Met with Texas A&M last meeting. Working on the screening and assessment meeting, got great feedback from committee. Working with us to compile feedback as well as cognitive testing they conducted. Working to revamp the instrument. Working to develop a memo to describe the feedback they received. Will be a large document. Will share a summary of the feedback and resulting changes. Coming soon. Hoping in couple of weeks to finalize the instrument for now to begin testing and develop training materials for staff to begin training by early summer. Identify pop to reach out to for the testing. Working through policy for selecting that pop.
 3. Not in a place to provide an update on _____.
 4. Opens to questions.
 5. Tucker - will we get to see update assessment before it gets tested? Yes, meeting next week with A&M will finalize and then share with committee. Will share NDCP section soon was not there for the previous meeting.
 6. Brown - who has been involved in revision process? Response - A&M created spreadsheet of comments. Brian and clinical staff and DADS and DSHS staff working through comments along with A&M. has not been sent back out for vetting.
 7. Tucker - q about medically dependent children's program. Will that be sent out for comments? Yes. Will share with committee and others for comments.
 8. Carlton - on track for September 2016? Yes.
 9. Tucker - this committee ends December 2016. With the year delay, will this committee continue on beyond that date? Cannot speak to legislation but intend to keep meeting.
 10. Brown - do we need to pursue this initiative? Munin - we can just keep going. Tucker - need to get agreement from commissioner about need to keep committee going post implementation.
- b. Prescribed Pediatric Extended Care Center Updates
1. Tucker - talked about this briefly. Introduce Laura Jordan and Amanda Hudgins.
 2. Laura, SPA in Medicaid Chip. Developed as a result of SB 492. Directed DADS to develop new licensure category for this benefit and a Medicaid fee for this.
 3. When prescribed, a child can receive 12 hours per day and can receive services appropriate to condition or medical status.
 4. Services will include comprehensive plan of care, services in plan of care, medical and nursing services. Nursing services core of the services. Therapy services not a part of the rate. Includes caregiver training and transportation, nutritional and dietary services.
 5. Who qualifies - medically or tech dependent children. Under 21. Definition in bill. In slides. Conditions that require continuous care.
 6. 5100 children in 2013 received private duty nursing. Roughly 17% in Medicaid MC.
 7. To be admitted. To a PPEC - under 21, eligible for TX health steps, dependent, stable for outpatient services, consent from adult, reside with adult, not in a 24 hour facility. Will have a choice to PPEC or private nursing. Does not supplant nursing. Cannot exceed rate for private duty nursing. Billable at hourly rate up to 4 hours. Therapists will bill independently.
 8. [slide show]
 9. Sept 2014 - license application became available. No one has applied yet. Medicaid enrollment avail in January. Holding rollout until STAR Kids rollout. Waiting for legislative changes around licensure. Cannot guarantee a 1:1 replacement of nursing hours. Costs assumer for licensure component but not delivery.
 10. This assessment module will help coordinate nursing with PPEC.
 11. PPEC facts - will require submission of a state plan but not a waiver. Medical policy draft will be released for comment. Will be avail in children with special health care needs but not chip. Will coordinate with DADS report on providers.

12. Because of high cost to start a PPEC, not anticipating statewide. Florida has 47 and it has been around 20 years.
13. Limit to 12 hours. Have to be prescribed and meet admission criteria. Excludes services that can be offered through school. Requires prior auth.
14. Assume nursing care assessment module will assess for this need. Client can then opt for one of a combination.
15. Email box for PPEC. Happy to respond to inquiries.
16. Licensure component - providers need to start licensure at DADS.
17. Sonleitner - question and concern - assumption majority of children receiving nursing are eligible for PPEC. Want to make sure there is choice. Also why is no one applying. Response - Laurie - SB 492 states it has to be a choice. Enforcing that in our rules and medical policy. 5000 are eligible but not assuming they will choose PPEC services. We assumed we would have 5 PPECs licensed per year. There will be a choice to the extent it is available. Needs to be prescribed specifically and separately from private duty nursing.
18. Munin - "allowed to" PPEC not requires.
19. Clarified technologically dependent - ventilator or g-tube. Denise - when parents choose not to do a g-tube they are not eligible. Clarifies medically or technologically dependent. But definition for tech will be the same. Ongoing skilled nursing is required. Tucker clarifies - when child is medically complex but not tech dependent. Issue for private duty nursing. Qualifications for PDN are getting narrower. Care requires nurse judgment. This is bigger than PPEC. It is a Medicaid state plan. When we discuss monitoring benchmarks. Laurie mentions we will look at medical criteria for PDN and PPEC rules. Will share draft policy with committee and welcome comments.
20. Denise - curious about lack of license applicants. Will we change criteria? Laura - expensive and requirements stringent. Specific concerns raised about licensure. Requires them to serve clients before they are licensed. Problematic from an insurance perspective and concerning about when payment will be forthcoming.
21. Tucker - how have other states done this. Can we do a provisional license? Laurie - will require statutory changes to change some of these requirements. Texas has more stringent licensing standards. Working on legislation this session.
22. Laura - difficulty is Medicaid payment on a provisional license.
23. Berhane - so pre-licensure work is not paid for? Clearly a barrier.
24. Tucker - since PPEC will be PDN licensed. Working with DADS on how licensure rules. Understand providers are seeking statutory changes. Not seen anything filed just yet.
25. Rosalba - who can apply for this license? Sounds like a modified nursing program. In el Paso there is a child care center. Are inclusive and provide services for kids with disabilities. Can day care apply. Laura - no cannot be co-located with a day care. R - so who can apply? Laura - PPECs established by corporations in other states. Expect them to enter market. It is facility based. Provisions are similar to nursing facilities.
26. Tucker in other states are there facilities where siblings can be cared concurrently. Is the colocation in other states an issue. Laura - not aware of licensure ins and outs. Toured some in LA - varied approaches. Some like day care.
27. Fuhrman - to provide services at 70% of existing rate, must be some sharing of services. Licensing requirements designate a ratio. Ratio of nurse to clients is 1:3 or 1:4.
28. Fuhrman - need to watch this if provided by a commercial provider.
29. Brown - legislation being reviewed. 750K to open. Have to provide transportation service. Do not know what rates are yet. Providers do not yet know what they will be paid for. Lot of provider barriers (another point I missed)
30. Tucker - concern about likelihood of PPECs in rural areas. Network adequacy concern. Need to build MCO requirement in rural area. But that will be hard. Did not look at nursing assessment tool with an eye toward PPEC.
31. Laura - looked at assessment module. The nursing module is more general.

32. Tucker - have we looked at assessments in other states. When we talk about contract piece. The choice needs to be built into contracts. Laura - draft language will prohibit steering clients to a particular choice.
 33. Gary Jessee - MCOs not looking to steer and we would want to prevent. Thinks MCOs would offer these supports and failure to provide services in home would drive off clients.
 34. Tucker just need to watch and provide quality standards.
 35. Gary - MCO would have ability to negotiate rates. With this new benefit we could structure rates without having provided services.
 36. Munin - same threshold. Just an alternative place of service. Not necessarily a new benefit. For network adequacy we are covered by PDN. Offering a different type of access.
 37. Berhane - stuck on inclusion. Worried if we narrowly define this. What is there to enrich a child's day. does not know what other states are doing. More to life than managing medication.
 38. Brown - concept of PPEC is social integration of a child. There are learning opportunities even though it is not school based. Requires hospital grade wiring and ventilation. Other costs are length of the application process. 12-18 month. To improve licensing process. Need make sure hen DADS inspects facility, can we give them their full license and then attend to monitor.
 39. Tucker - valid comments.
 40. Laurie - looking at July implementation and will bring this back to you.
- c. Updates on Administrative Processes (Michelle Erwin and Joshua Domingo)
1. In program operations area. Intro Kellie Dees and policy specialist.
 2. Talk about general managed care -
 3. First topic related to MCO rate issues. There is concern MCOs will unilaterally provide revised fee schedules. Timeline does not allow providers to meet with MCOS to discussion rate solutions. Proposing rate hearings. This is a concern. MCOs contract with providers at a percent of rate schedule or outside of rate schedule. Medicaid fee schedule can change and MCOs who do percentage would have to make changes.
 4. Last session providers cannot be across the board rate reduction without help of agency.
 5. Calhoun - our concern - if rates are pushed too low then _____. Erwin if rate is tied to a category can also be an issue.
 6. Concern that medical supplies will be commoditized. Crossing pattern on value and price.
 7. Erwin asked Vanhooose. Not aware provide being set by category. Multiple products within a code. Code price covers range of product. Opportunities to work with modifiers
 8. Laurie asks Michelle to send a code and we can look at products. Not differentiating _____
 9. Third party insurance issue. Medicaid is payer of last recourse. Will require prior auth
 10. Check contract - MCOs must show proof of tured(?). Concern they are not backdating claims.
 11. Interested in MCO billing, going back to the state of services
 12. Calhoun - when payer source ends, different requirements.
 13. Michelle - sometimes you do know there is other insurance. Can see where .
 14. Brown - told a story about a loop. Need admin changes for this solution
 15. Michelle - administrative plans are a problem. Need to define what documentation looks at.
 16. Calhoun suggest - if we had trials, we would have. Suggest be allowed to submit same application.
 17. Born 0 this will not work.
 18. Erwin - different plans do have different procedures for documents.

19. Calhoun - we see this in eligibility changes. We see this where we follow guidelines but switch providers. Not a frictionless way to address.
20. Born - each contract is detailed and comes with a provider manual. Maybe David John. If you take those complaints and work with Michele. Then you can see the MCO response. Every managed care or required to submit quarterly to report on complaint or appeals.
21. Buck - this most commonly happens over enrollment issues. System not update to show who the payer was. The cleaner the enrollment process is the _____ the providers.
22. Michelle - can look at file processes. To streamline and see where we can improve processing.
23. Josh -
 1. Pharmacist, here to talk about PDL. If a drug is approved by CMS, will add to list. PDL process started in 2004. Also looking to see if drug is safe effective and cost effective. Meet quarterly. Will take public testimony. Public shows up for these meetings. To discuss rates. Then we make recommendations on what should be preferred. Mostly approved. Commissioner decision posted on website. Product reviewed once per year.
 2. Schedule set far ahead so pharmacies can stock and public can comment
 3. For vendor drug program will go through pharmacy unless it is not a preferred just and then we need
 4. In case of drug samples.
 5. Products are generally approved.
 6. For VDP formulary - managed care plans follow formulary. Also have their list on their website or it links to our website. For PDL we have PA vendors.
 7. Whenever there is a prior authorization. But 20 hours they have to respond. Then can check status. Can respond to say they needed more time.
 8. Every pharmacy should know state rules that allow for a 72 hour override..
 9. HHSC has a website that outlines what you are looking for. There is a video for the 72 hour override.
 10. PDL does not apply, should pay for
 11. Born question - in a STAR Kids meeting. Talking about moving kids into managed care. Had VDP looked at drug costs for kids eligible for STAR Kids. Can we add this to agenda. Laurie - we can do that. Meeting Friday to talk about drug costs. Says drug costs are out of control. Notes Humera increased 17%. Why have costs increased? Lists drugs that costs went up. When we look at formulary for PDL, we can see costs have gone up. Lice treatment - gone up 5% because company was purchased.
 12. Josh says he works in formulary.
 13. Michelle - sounds like there are some specific drug issue being discussed. Some not within our control. Josh can take these specific questions back to the team to address.
 14. Born need to see what member cost per month - will always be new drug. Recognize limited by RFP process. Need to direct VDP to do that.

3. Member Input and Comments on STAR Kids Project

- a. Input and request for information.
- b. Long list of topics that we are researching and will provide updates as we make progress and staff are available.
- c. Buck - 3 items
 1. Once boards are out would like to see a master list of benefits for this product to have a full list of what SSI children are getting paid for by the state. Useful as we build our computer programs

2. List has flaws for providers. It was suggested of NPIs billing fro last 6 months might be a more accurate list.
 3. Personal request - wrestling with relationship of SHARS and STAR Kids. SHARS engagement varies by district. More info on how that operationalizes now would be helpful.
 - d. Tucker - SB 7 requires Texas home living waiver be rolled into star plus. Imagine star kids would have same roll in in 2017. Are you looking at that? Please add to a future agenda itme.
 - e. Berhane - one request to know where we are with cumbersome papaerwork requirement multiple signatures and hand signatures. Hope we are making this simpler. Brian - hoped to update today, but tied up today but should have at next meeting.
4. Discussion of the Medically Dependent Children Program
- a. Tucker introduces Lisa and Becky from DADS to present.
 - b. Discussion on how to make transition smooth.
 - c. All info on DADS website.
 - d. Becky gave brief waiver overview and description of service array. Lisa described how the program operates.
 - e. Becky
 1. Under 1915c
 2. CMS requires waiver services supplement accessed after private or Medicaid state plan services.
 3. MDCP are under 21, live in own home, family home, or foster home.
 4. 2014 - 2361 FTE - large majority are under 18.
 5. # on interest list is 27,480. Longest time on list can be 5-6 years. Cost limit cannot exceed 50% of nursing facility rate.
 6. Transition assistance services available as a one time service to those residing in nursing facility.
 7. Caregiver supports.
 8. Minor home modifications available. 7500\$ lifetime cap. Can be authorized up to 300 per month for repair and maintenance
 9. Adaptive aides available. Limited to DME and vehicle modification. No lifetime cap for adaptive aides.
 10. If indiv chooses CDS for any services, they are able to received financial management services provided by a FS agency including training on being an employer, taxes, screening,
 11. Includes respite - can be non-licensed attendant or skilled nursing depending on medical needs.
 12. Same structure for flexible family supports. To support independent living, job training, school, day care participation. Authorized with primary caregivers are at work, school, or in job training. Can be provided by various levels of skilled providers.
 13. Added employment assistance - to locate competitive employment in the community. Also supports self-employment
 14. Born question - 2361 kids on average in 2014. Based on service array, is there some global report DADS sends to CMS to provide costs are 50% of nursing costs. Becky - yes, in managing the waiver DADS works with HHSC on a 372 Report. Is this public information. Waiver on DADS website - provider resources - waiver programs - click on MDCP link - Appendix J of the waiver. Will check whether 372 report independently posted - that summarizes cost of the program.
 15. Rolled up under financial management services. Delineated by services. Will get back with more information on what is in appendix J,
 16. Born - what is the overlap in services covered by Medicaid and the MDCP waiver? Lisa - make sure there are no duplicative services. Go through an average schedule and compare.

17. Born - how many staff do you have?
18. Lisa - we have 5000 persons - 2K off interest list and 3K self directed. 77 FTEs plus support staff. 77 case managers and nurses. 100 admin staff. Dispersed across state.
19. Questions on becky
20. Tucker - Need 5600 number because we care about whole program. Indiv cost limit. Curious how this will work when roll-in to SK. Do you have breakdowns on kids with indiv modifications of care. So we have a sense of traditional providers MCOs will need to reach out to? Scary amount of work to be done. Relatively small number across state that require a lot of services. Do MCOs have signif trad providers for all of these services. So MDCP becomes a benefit under star health. DADS currently contracts directly with STPs. Who do MCOs reach out to. Feels like we are going into this without full picture.
21. Michelle - STP concerns - whenever we transition into managed care, providers who contract with DADS today for this, would be a part of the STP list.
22. Born - list does not say who was paid, says who was credentialed.
23. Michelle - when we get closer to implementation will provide MCOs with details on claims. Done this with other carve ins. STP list is the full list. Because each client allowed continuity of care with their providers.
24. Munin - once bid awards then we know who is in each region. It gets whittled down. Information gets more targeted. There is a process for this.
25. Michelle - there will be transition meetings with plans.
26. Tucker - just worried about economy of scales with such a small population. So much smaller than star plus population.
27. Stacey Mather - questions about wait list - any changes over last 5 years. What is age when added to list versus enrollment age. Lisa - will get that information to the committee. Tucker - also breakdown on SSI on waitlist and getting served. Becky - did a assume in a recent report. Assume Medical assistance only for entire population. Lisa takes note to provide. Tucker - also want average waiver budget. Breakdown. Brian says he will offer this.
28. Lisa - discuss enrollment process
 1. To be eligible must be under 21, citizen or qualified alien, live in Texas, meeting disability determination done under HHSC, valid medical determination. Goes through TMHP portal and goes to TMHP nurse then MD. Need a plan of care at or below 50% nursing care cost. Need to be at home or on own after 19. Need to require at least one services monthly. 27K average on waitlist. Is lower today because there have been significant releases from wait list since last October. Several thousand.
 2. Once they go off list, release # from list. Names go to regional staff. Case managers contact individuals, and schedule home visit. To medical and social assessment. Develop individual plan of care. Then assist family in completing family application if not already certified through SSI or TANF. Only child's income is counted. Within 30 days case manager has to verify meet Medicaid eligibility. Set service initiation date. Send notification to provider and family. Indiv must be assessed annually. Also had to reapply for Medicaid every year.
 3. Age out process. When turning 21 will go auto into star plus waiver. Will meet with family to discuss transition and what services will not longer be avail such as PDN. Check in with family every 3 months. Help them pick a plan and make that referral. Than transition on their birthday.
 4. Buck question - what is average time on MDCP program once they are in? Lisa - I can get that for you. What percent are qualified from list? Lisa - certification of 11%. Indiv can be on multiple interest lists but not enrolled in multiple waivers.

5. Buck - does this get more kids off wait list when we transition. Brian - currently no, the # of slots is not anticipated to change.
 6. Tucker - a couple of groups asked star kids roll out get handled the same as star plus. So if a child is on interest list for MDCP and are eligible they will transition offer automatically. No movement on this. Michelle - we hear that concern and are taking that back. There is some issue of workload if all of those people simultaneously need assessments.
 7. Lisa, - assess anyone
 8. Carlton - # on reassessments and requalifying - Lisa said she would get that information to committee.
 9. Mather - are you tracking when individuals do not meet qualifications, why. Lisa - we were tracking this, we held a workgroup meeting after 2013 0 attempt to ensure consistency. Did random sampling to see if we agreed with reason. Do track reason for denials. Many are transitioning to other waivers or aging out. Mather - why denied? Medical necessity, aging out, transition to other programs
 10. Ms. Carlton - once on program case manager contacts family every 6 months. Supposed to meet with family and discuss satisfaction, medical necessity.
 11. Rosalba - if you do not qualify for MN because health improved but is still in jeopardy and needs nursing care. What is the procedure to ensure services for child. Lisa - not a period of time can get back on the list. Have to get back on list or do money follows the person.
 12. Becky - Appendix is posted. 372 is not. We can get that to your committee. Think about data you want and we can get that for you.
 13. Tucker - supported employment services and indep living services very new. Becky - very new to HCCSAS did guidance for providers. Not run for #s. Tucker - can we can an update on that in the future.
 14. Brian - talk to us about what those services look like. Becky - best practice is to spend time doing an individualized client profile. To find out why they want that job.
 15. Mather - what coordination are you doing with schools for kids receiving job services training through their schools. DADS is working on that coordination issue now.
 16. Rosalba - so you get an employment coach? Becky - yes it is a continuum. Service array and provider qualifications on DADS website. Mirror those established by HHSC for its program.
 17. Rosalba - is this only for 18-20 yos? Becky - may use DARS - starts at 17 yo does assessment. Becky - not an age specifically for housing. But certainly a part of the transition discussions.
 18. Mather - nice to see transition plan mirror what it is in the schools which starts at 14.
 19. Angela - there are some initiatives occurring within conjunction with DADS. Project Search - allows young adults to work at host sites before they graduate. Have 10 young adults this year.
 20. Tucker - need another discussion about employment as we get closer to implementation.
 21. Mather - also looking at transition services because schools often provide a lot of support. May age out into DADS program. But if they lose job and go on wait list may take several years to get access for employment services.
 - 22.
5. Discussion of the Individual Service Plan (Kellie Dees)
 - a. Tucker noted there were handouts in packet. Introduced Kellie Dees

- b. In packet - extension of RFP including plan description and requirements. Also form 2410 which is the individual plan of care docs is using for MDCP.
 - c. Have gotten feedback from some stakeholders.
 - d. Looking for feedback on the flow. Opened for discussion.
 - e. Born comment - one thing very apparent is there are naming conventions that are confusing. Requests a matrix of forms and what they are for.
 - f. Denise - so will term individual plan of care will go away? What is the master tool.
 - g. Brian - RFP does not lay processes out sequentially or in a terribly logical flow. Born - map these things into how they are going to morph. Brian - will rearrange into how this would actually happen. Yes the SAI is the master assessment. Then move into service planning. Currently there is not a service plan for children in FFS.
 - h. Munin - curious want to hear from parents. Can we lay tools out sequentially and remove duplicative questions.
 - i. Born - request a quality of life score in the assessment. In order to look at long term impact of STAR Kids program. There is urgency in getting these documents settled.
 - j. Carlton - nice not to provide 2-3 hour history multiple times.
 - k. Munin - this is one of the biggest issues we will tackle. Opportunity for us to streamline this process and the documents.
 - l. Berhane - want to echo these comments. Incredible redundancy in all of these. Maybe the solution is a technology solution to auto populate.
 - m. Brian - struggled with how much we are comfortable prepopulating an assessment.
 - n. Berhane - comments that the assessors are so focused on filling boxes there is little conversation.
 - o. Munin - assessment tool is so robust. If a tool does not add value to process we need to look at eliminating it. Kellie - want to streamline this.
 - p. Laurie - assessment will feed a lot of these questions. Testing will tell us whether prepopulating is useful as well.
 - q. Berhane - having master list. Also allows provider groups from designing their own. ----- good rigorous set of evaluation tools will allow for quality tracking and benchmarking.
 - r. Born - so we are digitizing the screening and assessment tool. Will there be a centralized repository. Brian - working through specifications on that. Know we want assessment electronically and we want it to feed into an individual service plan. In terms of where data is house or how that system is built, it is still under discussion.
 - s. Item 11, 38.2 - recommend transition begin at 14 (Mather) schools are talking to families about waiver programs.
 - t. Carlton - happy to participate in assessment testing. Tucker - thinks it would very helpful as a committee member to go through this. Laurie says assessors can come to you. Tucker - we should make this happen.
 - u. Erwin - if any suggestion on things to incorporate in plan of care, let us know.
6. Public Comment*
- a. Marty had a question - participating by
 - b. Why air chambers on VDP but compressors and nebulizers are now.
 - c. Response - will get back to her on this.
7. Adjourn
- a. Minutes approved. Discussion on quality measures like Petes QL, supported employment, employment assistance, transition process, administrative simplification, master list of benefits. STP list of last 6 months. Something about Texas home living transition.
 - b. Brian - maternal and child health - project to support a set of standards for children with special health care needs. - Dr. Tapia - applicable to star kids. Would like them to come present to a future meeting.
 - c. Motion to accept meeting. Mather, Buck - aye
 - d. Next meeting June 25.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

STAR Kids Managed Care Advisory Committee
Meeting #8 • Meeting Minutes
Wednesday, September 2, 2015
9:00 a.m. – 12:30 p.m.

Health and Human Services Commission
Brown-Heatly Building ~ Public Hearing Room
4900 North Lamar Blvd.
Austin, Texas 78751

Agenda Item 1: Welcome and Opening Remarks

a. Member Introductions

Ms. Elizabeth Tucker, Chair of the STAR Kids Managed Care Advisory Committee, convened the meeting at 9 a.m. as she welcomed members to the eighth meeting of the committee and asked members to introduce themselves. Table 1 represents committee members that were present at the meeting.

Table 1: STAR Kids Managed Care Advisory Committee member attendance at the September 2, 2015 meeting

Table with 6 columns: MEMBER NAME, YES, NO, MEMBER NAME, YES, NO. Lists 18 members and their attendance status.

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

b. Adopt Meeting Minutes from June 25, 2015

Ms. Tucker referenced the draft of the June 25, 2015 meeting minutes.

Motion: Ms. Martha Strong made a motion to adopt the minutes as written. Mr. David Reimer seconded the motion. The motion passed via unanimous voice vote.

Agenda Item 2: Health and Human Services Commission (HHSC) Updates

Mr. Brian Dees, Health and Human Services Commission (HHSC), provided updates on STAR Kids. Highlights of the discussion are as follows:

- They are still in the midst of an active procurement, so there is no news concerning the Request for Proposal (RFP). The agency recently changed its procurement awards process in that they no longer make tentative awards, just final awards. The committee will be among the first to know when an award is made.
- Reliability testing of the STAR Kids Screening and Assessment Instrument (SAI) was slated to begin in August, but suffered a setback due to newly adopted policies regarding risk management and live subject research projects. Reliability testing is slated to begin later this month. They are still on track for September 2016.

Agenda Item 3: Discussion of Health Information Technology (IT) and Systems

Alan Scantlen, with HHSC Medicaid and CHIP, and Suja Pillai presented on this topic. Discussion highlights are as follows:

- HHSC is leveraging many existing state systems that support the Medicaid fee-for-service, CHIP, and Medicaid managed care programs. They maintain their records system and are providing content to the MCOs about a person, to better know what is going on with the individual, outstanding needs, long-standing services, etc.
- The program will be operating under a more involved process, to have information captured through the assessment, returned to the state and presented to the MCO so they can help govern out service plan and authorized processes. It becomes another mechanism to help the receiving MCO and providers working with them to better meet the needs of the child.
- HHSC will receive a copy of the assessment so they can have the broader picture of the population. If individuals or family opt to move from one MCO to another, there are mechanisms that will allow the MCO a short period of time of awareness in advance of the enrollment. Having the central repository provides for early awareness, which helps the MCO develop a plan and engage with the individual faster.
- After awardees have been notified, it was suggested that HHSC establish a workgroup for file transfer protocol with SAIs. HMOs receiving contracts would be working on systems and servers to store and act on those assessments, making it a perfect time to launch into the transfer process, file formats, etc. The service plan developed for each child will be housed at the state level, to have both instruments of information available. There is also a desire to make sure the SAI, service plan, and electronic health record are also owned by family.
- As they identify different subpopulations in the program, those are sent to MCOs to categorize individuals based on which waiver services that MCO is responsible for covering. There will also be a clear delineation of responsibilities conveyed to the MCOs, so they know how to react. The transfer of information cannot occur until the individual is enrolled to the MCO. After that definition is cast, data transfers starts happening.
- The STAR Kids SAI is intended to be an objective instrument. Reliability testing is intended to show the instrument performs the same on the same child regardless of the administrator. Thus, when a child moves from MCO to MCO, continuity of care provisions requires the receiving MCO to honor existing service authorizations for a

period of time, or until they re-administer the SAI. It depends on the MCO and circumstance in how quickly they believe the SAI needs to be re-administered.

Ms. Pillai, Senior Policy Analyst, Medicaid Health Information Technology, provided a high level overview of STAR Kids Managed Care partnership. She noted that the Health IT team conducted a survey of MCOs, looking at the landscape of health information technology, MCO provider portal capabilities and utilization and HIE connectivity landscape. The results showed that 10 of the 19 responding MCOs maintain a provider portal, but some of the detailed responses show less than 10% of MCO combined requests are submitted electronically. It is one of the highest features MCOs allowed on the portals, and one of the least utilized.

- The team focuses on electronic health records and health information exchange, connecting the individual EHR system.
- Electronic prescribing is one of the most important measures and has been one of the most widely adopted. One of the least utilized tools is the medication history check and e-prescribing of controlled substances. There has been a substantial increase in e-prescribing across all drug categories.
- Health information exchange is something plans can benefit from, as summary of care documents, continuity of care documents, etc. can be made available to plans and other stakeholders and is the key to transition of care.
- The emergency department event notification system project attempts to lower potentially preventable visits, another readmission, or a trip to the emergency department. They have received verbal approval for funding and are waiting on final CMS approval. Initially, the program would be for Medicaid patients notifications, but the infrastructure would be in place to open it up to all patients across the state of Texas.
- Privacy issues were identified as one of the biggest concerns that will necessitate HHSC to work with General Counsel to address various legal implications, differences in levels of confidential information that can be shared, and differences in how that information can be exchanged.

Action Items:

- Members may submit questions regarding the assessment to Mr. Dees who will seek answers from Mr. Scantlen.
- Mr. Scantlen can do a depiction point at a later date of how the timing works for the transfer of information.
- Mr. Scantlen will discuss with staff families having access to the assessment instrument so they have full disclosure and all the information.
- HHSC can look into accessing/electronically transferring information from personal health records some patients now use to collect health data as a possibility.
- Ms. Pillai will accept feedback regarding opt in procedures being something that should be addressed first so it can be addressed appropriately.

Agenda Item 4: Update on STAR Kids Outreach Plans

Ms. Emily Zalkovsky gave a review of the basic plan for outreach with the desire to get committee feedback. Highlights of the discussion were as follows:

- HHSC is still in active procurement process. Once awards have been made, HHSC will be able to release information. Member and provider information sessions will be

held in different cities to present information about the STAR Kids program so families and providers can ask questions. There will also be webinars for families and providers posted online. HHSC will also educate internal partners so they can relay information to others. Enrollment brokers are doing enrollment events all over the state, and will host meetings for families to discuss options and enrollment packers closer to the implementation date. HHSC will work with Maximus to develop various letters that will go to families at different intervals. The goal is to get people to have their choice in plans. Maximus can do outbound calls and help with the translation for non-English speaking individuals/families.

- The committee discussed outreach ideas to help people understand STAR Kids. Referrals for accessible locations to hold one of these initial meetings were solicited.
- As the families try to figure out which of the MCOs are going to provide the best for their needs, providers are not supposed to guide patients to a particular MCO. PCPs and specialists are not the ones who are legally allowed to discuss it with them.
- Videos for STAR Kids were suggested as a way to get information regarding the program out to families to help them make choices.
- It was suggested to look at the Children's Policy Council report to review the insight and information about the unique needs of this population. There needs to be a conversation about networks and parents who have been their own case managers for years, so this is not disrupted.
- Ninety days is short when looking at ongoing specialist appointments, as appointments can be made months in advance. Navigate Life has an incredible outreach plan that may be good for use as a model. Additionally, it would be great to outline 2016 meeting dates, so they can meet prior.
- Lunch has been a popular time for meetings, as are weekends, especially if respite for kids is provided. HHSC would like feedback on the timing of the sessions. They do want the meetings that are longer than an hour because they will be answering complex questions. There may be merit in bringing parent liaisons in from the school districts, as they know the kids and can get information to these parents about the outreach sessions. Hospitals may be a good meeting place, or they may be motivated to help with meetings or assist with outreach. Having the office staff (i.e., teachers and therapists who they see considerably more than their doctors) remind them about deadlines, etc. may be incredibly helpful. Also, having all the comparative charts and materials in waiting rooms may be a good idea, as parents are a captive audience while waiting for a therapy to end.
- Outreach sessions should be before 90-day period, and an interactive web conference would be good for parents who have trouble finding care. They also aim to target case managers and navigators, school district social workers, or the parent involvement coordinator for outreach.
- Once the plans are identified and the contracts are signed, there will be an MCO outreach and education plan. HHSC can be clear on contract about particular requirements, but what is harder to convey in a contract is the philosophy of what is trying to be done for a population, who these kids are, and what they need. The first step in the MCO education phase is instilling this into the MCOs.

Action Items:

- Look into an automated phone tree in the beginning and the option to opt in for text messaging as a method for disseminating information. These mechanisms have been shown to be cost effective and high rate of engagement with those tools. Other methods should also be explored.

Agenda Item 5: Tools and Planning to Transition from Children's to Adult Services

Ms. Peggy McManus and Patience White, co-directors of GOT Transition in Washington presented information on this topic to answer questions about rolling children with SSI into Medicaid managed care. Highlights from the member discussion are as follows:

- Ms. McManus referred to the PowerPoint presentation, *Adult Transition Planning in Texas STAR Kids: Lessons Learned from DC Medicaid MCO*, to talk about the alignment of MCO contract requirements and healthcare transition clinical recommendations, including six core elements, the DC managed care pilot, and ideas for next steps for STAR Kids and MCOs implementing new contract requirements. Transition requirements of the six core elements were compared side-by-side to STAR Kids.
- The transition pilot project with Health Services for Children with Special Needs (HSCSN) was developed with the aim of introducing customized core elements to a small group to evaluate their progress. The STAR Kids baseline for the project was level 1 on all of the elements, and was raised to a level 3 on each core element after the pilot during the 6 month period. Gaps in transition readiness were identified within the pilot group, a sizeable one being the gap in health literacy. The lessons learned from the pilot translated to suggested transition milestones for STAR Kids and Texas MCOs, as well as additional suggestions.
- The study highlighted the importance of looking at the STAR+PLUS program and exploring mechanisms to make the transition from STAR Kids more fluid and seamless. The success of this lies in the partnership between the pediatric and adult side.

Action Items:

- Mr. Dees will forward the Knights of Delphi study to committee members.
- Mr. Dees will provide the articles that show evidence of adhering to the six core elements as having a benefit of being a cost saving measure when they are available.

Agenda Item 6: Medicaid Title XIX Update

Mr. Alex Melis provided an update on the Medicaid Title Durable Medical Equipment (DME) form. Highlights of the member discussion were as follows:

- Under Associate Commissioner Kay Ghahremani's direction, there is an attempt to improve the process within federal laws and requirements.
- The DME is a sizeable form, the most important part is that it requires a physician's signature. Federal regulations require (and CMS expressly states) that a DME prescription include a physician signature on the written plan of care. An important goal is to work with CMS to find a way for Advanced Practice Registered Nurses (APRNs) and Physicians Assistants (PAs) to sign for some of these devices.

- An action group has been formed to review feedback on the DME form and attempt to mitigate concerns over negative impact on administrative processes as much as possible.
- HHSC is looking into the feasibility of implementing plans related to electronic signatures and electronic portals. The agency still has to determine how it will work in regards to a CFR that requires physician signatures.
- There are issues around the time spent reviewing and signing the forms (due to federal requirements), and frequency of forms coming back as denied (especially when it is for a previously established ongoing condition). Since not everything requires prior authorization, especially when they have already testified for its necessity. Handwritten signatures are an issue, but they are working on portals and integration into their EMR system.
- Patients are having a hard time getting supplies because of barriers. One challenge is that physicians are not aware of what common supplies are and what the prior authorization limits are, so it would help if the process for this determination was simplified. Additionally, TMHP needs to look at low cost items for which they are getting high volume of denials, as it always takes the process of a denial, then writing the letter of appeal, then approval to get the products. Huge amounts of money are wasted on denials for things that are easily appealed and previously approved.

Action Items:

- Mr. Melis stated he would take the issue of Title XIX for inexpensive and immediately needed products back to the attorneys and leadership to work through legal ramifications and feasibility, then pass it upstairs to leadership to make a decision of what can and cannot be done.
- Mr. Melis will send information out to the group he has already contacted related to a meeting/conference call. Mr. Melis will also send out his contact information to anyone who would like to participate.

Agenda Item 7: Public Comment

No additional public comment was provided.

Agenda Item 8: Discussion Topics for Next Meeting

The committee listed topics for discussion for the upcoming December 9, 2015 meeting:

- In regards to continuing outreach updates, there was a desire to see updates in calendar form, monthly leading up to September, for easy access to what is going on, what is going out to families, and what they could be doing. It would be good if they can get it prior to the December meeting.
- Look at getting meeting dates/times for the upcoming year.

Agenda Item 9: Adjournment

Ms. Tucker adjourned the meeting at 12:04 pm.



TEXAS HEALTH AND HUMAN SERVICES COMMISSION

**STAR Kids Managed Care Advisory Committee
Meeting #9 • Meeting Minutes
Wednesday, December 9, 2015
9:00 a.m. – 12:30 p.m.**

**Health and Human Services Commission
Brown-Heatly Building ~ Public Hearing Room
4900 North Lamar Blvd.
Austin, Texas 78751**

Agenda Item 1: Welcome and Opening Remarks

a. Member Introductions

Ms. Elizabeth Tucker, Chair of the STAR Kids Managed Care Advisory Committee, convened the meeting at 9 a.m. as she welcomed members to the eighth meeting of the committee and asked members to introduce themselves. Table 1 notes committee members' attendance at the meeting.

Table 1: STAR Kids Managed Care Advisory Committee member attendance at the December 9, 2015 meeting

MEMBER NAME	YES	NO	MEMBER NAME	YES	NO
Berhane, Rahel MD	X		Medellin, Glen MD	X	
Born, Christopher	X		Munin, Holly	X	
Buck, Ernest MD	X		Reimer, David	X	
Calhoun IV, John	X		Smith, Blake	X	
Calleros, Rosalba	X		Sonleitner, Denise	X	
Carlton, Catherine	X		Strong, Martha	X	
Fuhrman, Bradley MD	X		Torres, Reynaldo		X
Hines, Jeanne PhD		X	Trahan, Angela	X	
Hopkins, Tara	X		Tucker, Elizabeth	X	
Kearns, Diane	X		White, Rebecca	X	
Mather, Stacey	X				

Yes: Indicates attended the meeting

No: Indicates did not attend the meeting

b. Adopt Meeting Minutes from September 9, 2015

Ms. Tucker referenced the draft of the September 9, 2015 meeting minutes and asked if there were any changes.

Motion:

Ms. Holly Munin made a motion to adopt the minutes as written. Dr. Ernie Buck seconded the motion. The motion passed via unanimous voice vote.

Agenda Item 2: STAR Kids Implementation Updates

Mr. Gary Jessee, Health and Human Services Commission (HHSC), provided updates on STAR Kids implementation. Highlights of the discussion were as follows:

- HHSC is on the path to implement STAR Kids beginning November 1, 2016. A schedule of events will be published. The recent IDD carve-in showed the highest choice rate ever seen and it is the hope of the agency that it is even higher for this transition.
- Many MCOs have already signed initial contracts signed with providers. Regular stakeholder meetings are slated to continue.
- Outreach for enrollment is slated to begin in January/February.
- To aid with provider enrollment and credentialing, one thing on the horizon is a centralized credentialing system to be used across the network of health plans, for both Medicaid and commercial business.
- A lot of deliberation and consideration was put into choosing the MCOs, taking eleven months to review and evaluate Request for Proposal (RFP) responses. There is a new service delivery area map, effective November 1, 2016, for Medicaid and CHIP products, and 10 managed care entities. After contracts were awarded, an initial information session and in-person review was conducted to review requirements and the vision for STAR Kids to set the tone for working together. Weekly calls were also established with the MCOs to address questions and educate the plans on expectations.
- A goal of the agency is to record trainings for archival reference. Mr. Brian Dees will get a high level document of topics to be covered at weekly meetings, comparable to the document on information sessions, to Ms. Denise Sonleitner.
- Regarding questions of how Community First Choice (CFC) works, families do not have to wait until they are enrolled in managed care to get CFC, it has been implemented in fee-for-service.
- Mr. Dees did not have the numbers for children previously getting Personal Care Services (PCS) who are now getting CFC. He will discuss this with DSHS staff to see if people are being screened out with the assessment.
- The functionality of the Medical Necessity Level of Care (MNLOC) is incorporated into the STAR Kids Screening Assessment Instrument (SAI). Mr. Dees can share the draft of what the assessment looks like now, which is the same as the MCOs have received.
- An issue was raised that the individual service plans (ISPs) can be so long and complex, it becomes an unworkable tool. The agency has been working on ISPs for the past few months, even soliciting feedback from committee members on how to structure the ISP. Mr. Dees will be able to share the ISP format with MCOs and committee soon. Optimally, service coordinators would take information from the SAI, digest it, record it in the ISP, and then use that knowledge to have conversations with the family.
- Most MCOs are concerned about initial bolus of assessments. This raised the issue of parents having the ability to fill out portions of the SAI ahead of time, in an effort to streamline and save time in service coordinator visits. According to Dr. Rahel Berhane, there are portals in their system for families to fill out goals, dreams, and expectations, and it would be possible to incorporate questions from the assessment.

Mr. Dees stated that a web-enabled instrument for parents to fill out has not been discussed by the agency, but it is in the realm of possibilities.

- Mr. Dees will get the number of people who have volunteered to take reliability trials in the assessment tool. He will also take back the suggestion of taking the mock assessments and putting them through the process of developing the ISP.
- One of the biggest barriers is that the assessment is very time consuming, which may result in the sample of families not being diverse enough and potentially not indicative of the population who needs the services. This issue may cause the tool to be not well validated.
- Suggestions were made for more flexibility in allowing social workers to be involved in the assessment, as well as higher and more involved coordination among health plans and physicians serving children with medical complexity. Mr. Dees has heard the suggestions for exploring more flexibility, how assessments are administered, how service planning is done, and how the systems work together, and will take the suggestions back. Additionally, Mr. Dees stated that while he wants to explore what flexibility looks like in terms of administering the assessment, there are real limitations to what the systems people can do in order to be ready to launch the program November 1, 2016.

Action Items:

- Mr. Dees will get a list of topics to be covered at weekly meetings to Ms. Sonleitner.
- Mr. Dees will share with members the draft of the STAR Kids Screening Assessment Instrument.
- Ms. Emily Zalkovsky will provide a high level list of the categories the MCOs have shown concern over, training topics, and the training piece required at the next meeting.
- Mr. Dees will determine the number of people who have volunteered to take reliability trials in the assessment tool. He will also take back the suggestion of taking the mock assessments and putting them through the process of developing the ISP.
- Mr. Dees will take the suggestions for exploring more flexibility, how assessments are administered, how service planning is done, and how the systems work together back to staff.

Agenda Item 3: Discussion of STAR Kids Outreach Plans

Ms. Kellie Dees presented on outreach plans. Discussion highlights are as follows:

- Ms. Dees referred to a document concerning the STAR Kids information sessions finalized for January and February. Houston and El Paso sessions are pending a confirmed date, and the Waco/Belton session is being planned. There are family and provider sessions, and MCOs will be in attendance. Webinars are being planned for March. They will be posted as public meetings on the website.
- Ms. Dees will go back to the communication department to see if language can be drafted and sent to the committee for feedback in how to communicate the importance of these sessions to parents.

- Anyone on the advisory committee interested in attending the sessions can email the attending staff to let them know. Ms. Zalkovsky will send a list of the staff attending each session to the members, as soon as such information is available.
- Mr. Dees brought up the importance to outreach internally to get case managers, and the people they care for, to attend the meeting. Additionally, Ms. Rebecca White suggested informing the committee of the message to be conveyed on the flyer and allowing the committee inform HHSC of the best way to communicate it for clarity.
- The provider sessions are for anyone providing care in the Medicaid system, not restricted to the physicians. Dr. Glen Medellin also suggested a second information session for the lower valley, as the one scheduled in the upper valley may be difficult to get to for some valley residents. Additionally, care must be taken to make sure sessions are not perceived as an endorsement at one hospital, and that the places where sessions are held provide free parking.
- Ms. Stacey Mather suggested to utilize professional associations as an outreach for providers and to provide flyers to get them out to patients. Ms. Rebecca White suggested sending families text alerts. Ms. Dees will take these suggestions back to the communication department for consideration with the other methods they have been looking at, such as making a video.
- Ms. Calleros will follow up with Mr. Dees to discuss having this information at the Texas Parent to Parent meeting in June.
- Due to time constraints, the agency had to plan sessions based on breakdowns of where people are located for STAR Kids. As a result of these constraints, the two webinars were set up that will be archived for future viewing.
- Mr. Dees will share with Ms. Dees the one page flyer collaboratively put together with Mr. David Reimer, to be a starting point. Ms. Tucker recommended getting something to the committee members as well as to the Children's Policy Council members.

Action Items:

- Ms. Dees will talk to the communication department to see if language can be drafted and sent to the committee for feedback in how to communicate the importance of these sessions to parents.
- Ms. Emily Zalkovsky will send a list of the staff attending each session to the members, as soon as such information is available.
- Mr. Dees will email the committee with the Houston date once it is set.
- Ms. Zalkovsky will find out about whether parking will be free at all sessions.
- Ms. Dees will talk to the communication department to share other methods the committee suggested, such as making a video.
- Ms. Calleros will follow up with Mr. Dees to discuss having this information at the Texas Parent-to-Parent meeting in June 2016.
- Mr. Dees will share with Ms. Dees the one page flyer collaboratively put together with Mr. Reimer, to be a starting point. Mr. Dees will also send something to the committee members and the Children's Policy Council members.

Agenda Item 5: Pharmacy costs for STAR Kids population

Ms. Elida Lopez and Mr. Josh Dominguez gave an overview of pharmacy costs and pharmacy data as it relates to STAR Kids, referring to a handout with a high level overview pharmacy cost relating to STAR Kids. Highlights from the member discussion are as follows:

- Drugs for STAR Kids population are pretty standard for what is being seen for Medicaid in general. The 12 categories account for 52 percent of the patient population.
- Ms. Xiaoling Huang, Director of Data Analytics, Medicaid and CHIP, HHSC, can provide the ranking of drug usage by patient count and prescription cost, for September 2014 through March 2015.
- Many brand name drugs are covered by rebates. Notices are sent out when there are big drug changes. All MCOs cover the same drugs similarly; thus drug coverage is not a factor in MCO choice.
- MCOs can adopt the same restrictions regarding clinical edits, but they cannot be more stringent than those presented by the agency.

Action Items:

- Ms. Huang will provide the ranking of drug usage by patient count and prescription cost for September 2014 through March 2015.

Agenda Item 6: Committee Member Discussion

Ms. Tucker began the discussion praising the minutes from the last meeting, and asked if anyone had questions about the status of the action items. Highlights of the committee member discussion were as follows:

- Ms. Zalkovsky will try to get the committee an update on the continuation of HIPP. According to Ms. Tucker, at a stakeholder meeting Mr. Jessee stated his intention to strengthen and increase HIPP through modernization and improvement in access.
- The presentation by Mr. Alex Melis on the DME piece has resulted in an action group formed to review feedback. The Children's Policy Council (CPC) has been invited to participate by Ms. Denise Sonleitner, but she is not aware if any CPC members have been participating. Mr. Dees will find out this information and get back to her.
- The next meeting is scheduled for March 2, 2016. Anyone with proposed topics or agenda items was encouraged to send them to Mr. Dees, if they were unable to do so at the present time.

Action Items:

- Ms. Zalkovsky will try to obtain an update on the continuation of HIPP.
- Mr. Dees will find out if any CPC members are participating in the newly formed action group and relay information to Ms. Sonleitner.

Agenda Item 7: Public Comment

Cynthia Gonzales, Institute of Child Health Services in the Rio Grande Valley, discussed the desire to have another training center in the lower valley, as previously mentioned by Dr. Medellin. Additionally, she made a comment to utilize the Medicaid website in finding providers, as well as a suggestion for placing the assessment tool on the TMHP website for social workers to use and actively promote. Regarding not having enough volunteers from the valley, Ms. Gonzales suggested reaching out to the promotora association and the traveling qualified healthcare clinics for assistance.

The next meeting is scheduled for March 2nd. If a workgroup gets started up, members should be made aware and queried for interest. Dr. Darcy McMaughan is still interested in sharing her information and will forward it to Mr. Dees for distribution, and is open to corresponding via email. In the meantime, Mr. Dees will fill in and answer questions regarding the trials and anything related to the assessment.

Action Items:

- Mr. Dees will forward Dr. McMaughan's presentation to the committee as soon as he receives it.

Agenda Item 8: Adjournment

Ms. Tucker adjourned the meeting at 12:11 pm.

DRAFT NOT APPROVED

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name: State Medicaid Managed Care Advisory Committee

Number of Members: not known until appointed but no more than 23

Committee Status (Ongoing or Inactive): Ongoing
 Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: 7/1/2016
Date to Be Abolished: 1/1/2020

Budget Strategy (Strategies) (e.g. 1-2-4): 2.3.1
Strategy Title (e.g. Occupational Licensing): Medicaid Contracts & Administration
Strategy Title:

State / Federal Authority
 State Authority
 State Authority
 State Authority
 Federal Authority
 Federal Authority
 Federal Authority

Select Type	Identify Specific Citation
Admin Code	Sec. 351.827 (Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' Direct Expenses

Committee members who are recipients for family member of recipients may be reimbursed. I won't be able to estimate travel costs until committee is appointed.

There were only 2 meetings in '15
 See Comment 1 below

	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel		\$2,576	\$2,576.00
Personnel		\$20,000	\$20,000
Number of FTEs		0.0	0.0
Other Operating Costs		\$400	\$400
<i>Total, Committee Expenditures</i>		\$22,976	\$22,976

Committee Members' Indirect Expenses

	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0
Personnel	\$0	\$0
Number of FTEs	0.0	0.0
Other Operating Costs	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0

Method of Financing

	Estimated Est 2016	Budgeted Bud 2017
Method of Finance		
1 - General Revenue Fund	\$11,488	\$11,488
555 - Federal Funds	\$11,488	\$11,488
	\$0	\$0
	\$0	\$0
	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0

Meetings Per Fiscal Year

	4	4
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Committee Description: The State Medicaid Managed Care Advisory Committee provides recommendations and ongoing input to HHSC on the statewide implementation and operation of Medicaid managed care. The committee looks at a range of issues, including program design and benefits, systemic concerns from consumers and providers, efficiency and quality of services delivered by Medicaid managed care organizations, contract requirements for Medicaid managed care, provider network adequacy, and trends in claims processing.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. No current by laws

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings? Committee will meet quarterly in Austin. Rules require semi-annual meetings.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.
 NA-committee has not had its first meeting.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?
 NA-committee has not had its first meeting.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ? Yes 4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees? No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015? NA

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.
 NA

6. Have there been instances where the committee was unable to meet because a quorum was not present? Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. NA-committee has not had its first meeting.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?
 The committee will take public comment at all meetings and solicit public input through public comment in the development of its recommendation report. Meeting notices will be posted on the HHSC website.

7b. Do members of the public attend at least 50 percent of all committee meetings? 7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.
 NA--committee has not had its first meeting.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute? No 10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area? No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)? Retain

11b. Please describe the rationale for this opinion.
 Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission? No

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

When the committee was reconstituted in 2016, two committees were combined within SMMAC--STAR+PLUS Nursing Facility Advisory Committee and STAR+PLUS Quality Council.

ASSESSMENT OF ADVISORY COMMITTEES

April, 2016

Agency #529 Health and Human Services Commission - Business unit: Office of Acquired Brain Injury (OABI)

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Texas Brain Injury Advisory Council (Texas BIAC)		
Number of Members:	15		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	7/1/2016	Date to Be Abolished:	6/30/2020
Budget Strategy (Strategies) (e.g. 1-2-4)		Strategy Title (e.g. Occupational Licensing)	
Budget Strategy (Strategies)		Strategy Title	

State / Federal Authority
State Authority

State Authority

State Authority
Federal Authority
Federal Authority
Federal Authority

Select Type	Identify Specific Citation
Statute	
Admin Code	The Texas Brain Injury Advisory Council (Texas BIAC) is established in accordance with Texas Government Code §531.012.(Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Committee Members' <u>Indirect</u> Expenses	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
	0	0	0

Committee Description:

The Texas BIAC is a brain injury survivor, family member/caregiver, professional and service provider stakeholder group that advises the HHSC Executive Commissioner and the HHSC Office of Acquired Brain Injury (OABI) on strategic planning, policy, rules, and services related to the prevention of brain injury; rehabilitation; and the provision of long term services and supports for persons who have survived brain injuries to improve their quality of life and ability to function independently in the home and community.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: To be developed once the Texas Brain Injury Advisory Council begins to meet.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

N/A

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

N/A

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:

Number of Members:

Committee Status (Ongoing or Inactive): Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.

Date Created: **Date to Be Abolished:**

Budget Strategy (Strategies) (e.g. 1-2-4): **Strategy Title (e.g. Occupational Licensing):**

Budget Strategy (Strategies): **Strategy Title:**

[State / Federal Authority](#)
[State Authority](#)
[State Authority](#)

[State Authority](#)
[Federal Authority](#)
[Federal Authority](#)
[Federal Authority](#)

Select Type	Identify Specific Citation
Statute	Texas Government Code, Section 531.052
Admin Code	Sec. 531.021 (Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel- See comment 13 below.	\$3,476	\$1,738	\$3,476
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$3,476	\$1,738	\$3,476

Committee Members' <u>Indirect</u> Expenses	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Method of Financing	Expended Exp 2015	Estimated Est 2016	Budgeted Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$869	\$1,738
555 - Federal Funds	\$0	\$869	\$1,738
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	4	2	4
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Committee Description:

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes.

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

7b. Do members of the public attend at least 50 percent of all committee meetings?

7c. Are there instances where no members of the public attended meetings?

8. Please list any external stakeholders you recommend we contact regarding this committee.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

9b. Please describe the rationale for this opinion.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

11b. Please describe the rationale for this opinion.

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

n/a

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

*Travel expenses: University of Texas Center for Disability Studies funded travel for the committee since fiscal year 2010. The CDW was included in a rider by the 84th legislature for FY 2016-2017 allowing travel funding through the HHSC budget.

Consumer Direction Workgroup

OPERATING PROCEDURES

Legal Mandate

The Consumer Direction Workgroup (Workgroup) is established under the authority of Section 531.052 of the Government Code (Attachment 1).

Purpose of Workgroup

The purpose of the Workgroup is to advise the Health and Human Services Commission (HHSC) concerning the delivery of services through consumer direction in all programs offering long-term services and supports to ensure that consumers have access to a service delivery model that enhances a consumer's ability to have freedom and exercise control and authority over the consumer's choices, regardless of age or disability; and to assist the Commission in developing and implementing consumer direction models and in expanding the delivery of services through consumer direction.

The Workgroup is subject to legal obligations and limitations including rules and other laws relating to HHSC advisory committees.

Duties

The duties of the Workgroup include:

- 1) Developing recommendations to:
 - Expand the delivery of services through consumer direction to other programs serving persons with disabilities and elderly persons
 - Expand the array of services delivered through consumer direction
 - Increase the use of consumer direction models by consumers
 - Optimize the provider base for consumer direction
 - Expand access to support advisors for those consumers receiving long-term services and supports through consumer direction
- 2) Monitoring national research for best practices in self-determination and consumer direction
- 3) Developing recommendations and providing assistance regarding consumer outreach efforts to increase informed choices, skills, opportunities, and supports as a means to lead self-determined lives through the use of consumer direction models
- 4) Not later than September 1 of each even-numbered year, reporting to the Legislature regarding the activities of the Workgroup.

Membership/Appointments

The Workgroup must include:

- Representatives of HHSC, appointed by the Executive Commissioner
- Representatives of the Department of Aging and Disability Services (DADS), appointed by the DADS Commissioner
- Representatives of the Department of State Health Services (DSHS), appointed by the DSHS Commissioner
- Representatives of the Department of Assistive and Rehabilitative Services (DARS), appointed by the DARS Commissioner
- Consumers or potential consumers of the array of services provided through consumer direction jointly appointed by the Executive Commissioner and the commissioner of the health and human services agency that administers the program providing the service
- Advocates for elderly persons who are consumers of the array of services provided to elderly persons through consumer direction, appointed by the Executive Commissioner
- Advocates for persons with disabilities who are consumers of the array of services provided to persons with disabilities through consumer direction, appointed by the Executive Commissioner
- Providers of services to be provided through consumer direction appointed by the Executive Commissioner
- Representatives of the Texas Workforce Commission (TWC), appointed by the TWC Executive Director
- Representatives of any other state agency as considered necessary by the Executive Commissioner, appointed by the governing body of their respective agency
- Representatives of any other state agency as recommended by the Workgroup and approved by the Executive Commissioner, appointed by the governing body of the respective agency
- Any other public representative appointed by the Executive Commissioner

NOMINATION OF PUBLIC MEMBERS

The State Medicaid Office staff solicits nominations of public members from consumers, advocates, private providers, trade organizations, and other stakeholders. Staff from the Department serving a consumer reviews nominations and makes recommendations to the Commissioner of that Department. When the Commissioner has approved a nomination it is forwarded to State Medicaid staff. The State Medicaid staff reviews and recommends nominees to the Executive Commissioner of HHSC for appointment. The Executive Commissioner of HHSC reviews the nominations, and in his or her discretion, makes the final selection and appoints members to the Workgroup.

TERMS OF MEMBERSHIP

Public members serve three year staggered terms or until a successor is appointed. For the initial terms on the Workgroup, lots will be drawn to determine which members' terms expire December 31, 2008, 2009, and 2010. Members may be reappointed.

Members representing state agencies serve at the discretion of the appointing agency.

A majority of the members of the Workgroup must be composed of consumers and advocates.

VACANCIES

Members serve at the discretion of the appointing agency and may be removed prior to expiration of their term if the appointing agency determines that the member is not meeting the responsibilities outlined below or that removal is in the best interest of the agency or the health and human services enterprise. In the case of a vacancy created by such removal, death or resignation of a member, the appointing agency will appoint an individual to serve the remaining portion of that term.

COMPENSATION

A member of the workgroup who represents a state agency serves at the discretion of the appointing agency and receives no additional compensation for serving on the workgroup.

Reimbursement may be available for consumer members or family members for respite, travel for members and travel of members' personal attendants if necessary for the member to attend the official meetings of the Workgroup.

RESPONSIBILITIES OF MEMBERS

- Members are expected to attend Workgroup meetings. Prior notice should be given to the presiding officer or designee if a member is unable to attend a meeting. Alternates will be allowed to attend meetings for members who are unable to attend but can not be involved in the decision making process or voting by the Workgroup.
- A member who is absent two consecutive quarterly meetings without prior notice and without good cause as determined by the State Medicaid Director or who establishes a pattern of absenteeism may be deemed unable to discharge the duties of a Workgroup member.
- All members are expected to perform the following tasks:
 - Keep their agencies, organizations and/or networks informed of the Consumer Direction Workgroup's activities;
 - Solicit input and, when necessary, approval from their agencies, organizations and/or networks for policies, positions and activities; and
 - Review Workgroup agenda items and the supporting documentation before meetings and participate in discussions;
 - Maintain a level of integrity that warrants public trust;

- Members are expected to abstain from voting on any issue that would provide personal gain or is otherwise a conflict of interest, or creates the appearance of a conflict of interest.

OFFICERS

The Executive Commissioner appoints a member of the Workgroup to serve as presiding officer. Members of the Workgroup may elect any other officers necessary.

Meetings

- Meetings of the full Workgroup will be quarterly or at the call of the presiding officer.
- Committee meetings or conference call meetings may be scheduled as needed.
- Meetings will be held during regular HHSC working hours and will be open to the public.
- Meetings will include an opportunity for public comment to allow for the participation of non-members.
- The Workgroup will keep written minutes of the quarterly meetings.
- Meetings will be conducted using the Robert's Rules of Order, Newly Revised.

VOTING

The members representing state agencies are non-voting members.

Each voting member has one vote. An alternate attending in the place of a voting member will not be counted toward the quorum and will have no vote. Recommendations of the Workgroup will be adopted by a majority vote of voting members on a motion duly made and seconded.

QUORUM

A majority of the voting members of the Consumer Direction Workgroup constitutes a quorum. Alternates to voting members are not counted toward a quorum. A Workgroup meeting must have a quorum in order to take or recommend any action.

REVISIONS

The Executive Commissioner of HHSC may revise these operating procedures at any time with input from, and notification to, the members of the Workgroup.

Approved by the Consumer Direction Workgroup September 19, 2008

Attachment 1

GOVERNMENT CODE
SUBTITLE I. HEALTH AND HUMAN SERVICES
CHAPTER 531. HEALTH AND HUMAN SERVICES COMMISSION
SUBCHAPTER B. POWERS AND DUTIES

Sec. 531.052. CONSUMER DIRECTION WORK GROUP. (a) A work group is created to:

(1) advise the commission concerning the delivery of services through consumer direction in all programs offering long-term services and supports to ensure that consumers have access to a service delivery model that enhances a consumer's ability to have freedom and exercise control and authority over the consumer's choices, regardless of age or disability; and

(2) assist the commission in developing and implementing consumer direction models and expanding the delivery of services through consumer direction under Section 531.051.

(b) The work group is composed of:

(1) representatives of the commission, appointed by the executive commissioner;

(2) representatives of the Department of Aging and Disability Services, appointed by the commissioner of that agency;

(3) representatives of the Department of State Health Services, appointed by the commissioner of that agency;

(4) representatives of the Department of Assistive and Rehabilitative Services, appointed by the commissioner of that agency;

(5) consumers or potential consumers of the array of services provided through consumer direction under Section 531.051, jointly appointed by the executive commissioner and the commissioner of the health and human services agency that administers the program providing the service;

(6) advocates for elderly persons who are consumers of the array of services provided to elderly persons through consumer direction, appointed by the executive commissioner;

(7) advocates for persons with disabilities who are consumers of the array of services provided to persons with disabilities through consumer direction, appointed by the executive commissioner;

(8) providers of services to be provided through consumer direction, appointed by the executive commissioner;

(9) representatives of the Texas Workforce Commission, appointed by the executive director of that commission;

(10) representatives of any other state agency as considered necessary by the executive commissioner, appointed by the governing body of their respective agency;

(11) representatives of any other state agency as recommended by the work group and approved by the executive commissioner, appointed by the governing body of the respective agency; and

(12) any other public representative appointed by the executive commissioner.

(c) A majority of the members of the work group must be composed of consumers and advocates described by Subsection (b).

(c-1) Duties of the work group created under this section include:

(1) developing recommendations to:

- (A) expand the delivery of services through consumer direction to other programs serving persons with disabilities and elderly persons;
 - (B) expand the array of services delivered through consumer direction;
 - (C) increase the use of consumer direction models by consumers;
 - (D) optimize the provider base for consumer direction; and
 - (E) expand access to support advisors for those consumers receiving long-term services and supports through consumer direction;
- (2) monitoring national research for best practices in self-determination and consumer direction; and
 - (3) developing recommendations and providing assistance regarding consumer outreach efforts to increase informed choices, skills, opportunities, and supports as a means to lead self-determined lives through the use of consumer direction models.
- (d) A member of the work group serves at the will of the appointing agency and receives no additional compensation for serving on the work group.
- (e) The executive commissioner shall appoint a member of the work group to serve as presiding officer, and members of the work group shall elect any other necessary officers. The work group shall meet at the call of the presiding officer.
- (f) The work group is not subject to Chapter 2110.
- (g) Not later than September 1 of each even-numbered year, the work group shall report to the legislature regarding the activities of the work group.

Added by Acts 1999, 76th Leg., ch. 1288, Sec. 1, eff. June 18, 1999. Amended by Acts 2003, 78th Leg., ch. 799, Sec. 1, 2, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 576, Sec. 3, eff. September 1, 2007.

Acts 2007, 80th Leg., R.S., Ch. 576, Sec. 4, eff. September 1, 2007.

**Consumer Direction Workgroup
Regular Quarterly Meeting
10:00 a.m. - 3:00 p.m.
Brown-Heatly Building, Rooms 1420-1430**

Friday, May 29, 2015

MINUTES

CDW Members Present:

Nancy Crowther
Ricky Broussard
Ron Cranston
Linda Levine
Rebecca White

CDW Members Present: (via phone)

Helen Baker
Flora Brewer

Members Absent:

Janet M. Brown
Leslie Curtis
Shelley Dumas
Jennifer Farrar
Kristen Hebert
Kevin Jeffrey
Renee Lopez
Jackie Mason
Joshua Oyeniyi
Marcela Patrick
David Ramos
Ramona Salomons
Terri Stellar
Gyl Switzer
Sylvia Vargas
Michelle Zadrozny

Agency Members:

Maria Benedict, Presiding Officer, HHSC
Amanda Dillon, HHSC
Ivy Goldstein, DSHS
Betsy Johnson, HHSC
Elizabeth Jones, DADS
Jimmy Perez, HHSC
Jonas Schwartz, DARS
Dena Stoner, DSHS
Dina Testoni, TWC

Guests:

Jennie Baird, Angels at Home
Anna DiCarlo, DADS
Stephanie Dickerson, Angels at Home
Rose Dunaway, Girling Healthcare
Bob Kafka, ADAPT
Rachel Kane, MHSA
Nicole Matthews, DADS
Gene Whitten-Lege, I-HAS
Pat Whitten-Lege, I-HAS

1. Welcome, Introductions, and Announcements - Nancy Crowther.

Ms. Crowther announced that there was no quorum present so the Consumer Direction Workgroup (CDW) was unable to vote on March 13, 2015 minutes and committee recommendations. New state agency representatives include Amanda Dillon (HHSC) and Betsy Johnson (HHSC). Maria Benedict (HHSC) is the new Presiding Officer for the CDW, a position previously occupied by Kay Lambert. Materials sent to the workgroup from Sallie Allen via email have been resolved. Members should be able to receive and open emails.

Ms. Crowther provided an update on her letter of concern and recommendation to Executive Commissioner Kyle Janek regarding the continuation of the CDW in accordance with the Sunset legislation (Senate Bill 200). Becky Brownlee, Director of Policy Development Support (HHSC), updated the committee indicating the CDW is one of the committees that are scheduled to be eliminated in the law. There is a clear mandate in the bill that HHSC will continue to have a robust advisory committee process involving a number of different issues. With the passage of the bill, HHSC will analyze the advisory committee structure and make recommendations to determine if committees will be reinstated in their current form, merged with other committees, or discontinued. The agency is required to post the status and the rationale by November 2015.

Action items from the last quarterly meeting were addressed. Rhonda Pratt created the Electronic Visit Verification (EVV) cost savings information handout per Mr. Cranston's request at the last quarterly meeting. The handout will be shared with members via email. There was an inquiry regarding minimum standards required of an EVV contract and contract time period allowed. The Minimum Vendor Requirements can be found in the HHSC EVV contract under Section 2.4 *Contractor Responsibilities*. All vendors selected for participation in the HHSC EVV initiative, and as a condition to remain eligible to participate, will be required to demonstrate and maintain compliance with the HHSC-approved minimum standard requirements as set forth in Sections 2.4.1 through 2.4.6. Additionally, HHSC would like to schedule live demonstrations conducted by all three vendors this summer after the last implementation date of June 1. The date will be determined in late June based on implementation status at that time. Vendor CDS training information is under review by the state and will be incorporated in the vendors' webinar and online training materials once completed and will be shared accordingly. Mr. Broussard requested an in-person EVV demonstration.

Lastly, as a result of the last minute low attendance meeting turn out, Ms. Crowther announced any meeting cancellations or changes will be communicated by Sallie Allen, Maria Benedict, or Nancy Crowther. No other committee members or other individuals can decide meeting changes.

2. Approval of Minutes (March 13, 2015 CDW Meeting).

Quorum was not present and the workgroup was not able to vote on the approval of minutes. If quorum is present at the next Consumer Direction Workgroup meeting scheduled for Friday, July 24, 2015, the workgroup will vote on the approval of minutes.

3. Chair report on Consumer Directed Issues from State and National Organizations and Associations - Nancy Crowther.

The base wage for personal attendants paid by certain contractors and FMSAs has increased from \$7.86/hr. to \$8.00/hr. Department of Aging and Disabilities Services (DADS) Council will meet on June 11, 2015 to discuss rates. Ms. Levine and Mr. Cranston highlighted the challenges associated with an \$8.00/hr. base wage to include hiring and retaining quality attendants in a competitive market. They encouraged the CDW to continue to work toward raising the hourly rate to \$10.00 to strengthen consumer directed services (CDS) in Texas. Mr. Cranston highlighted the advantage of utilizing CDS.

Ricky Broussard inquired about the DADS employee rate at state facilities. Mr. Cranston stated he believes the rate is \$12.00/hr.

4. Legislative Update on Bills Impacting Consumer Direction - Nancy Crowther.

Mr. Cranston reported supported living centers will remain open and are no longer at risk to being closed or consolidated. Ms. Levine inquired on the length of this decision to keep supported living centers open.

Ms. Crowther indicated HB 2656 did not pass but the identical Senate companion, Senate Bill (SB) 1880, passed both the House and the Senate and is pending the Governor's action. This bill relates to certain Department of Family and Protective Services (DFPS) abuse investigations. HB 3523 regarding the expansion of the Intellectual and Developmental Disabilities (IDD) System Redesign provisions that passed in SB 7 last session was amended by the Senate and sent back to the House for a vote.

5. Discuss Consumer Directed Services (CDS) in the Consumer Managed Personal Attendant Services (CMPAS) program - Nancy Crowther and Ron Cranston.

Ms. Crowther provided an overview of CMPAS eligibility. CMPAS consumers are for individuals who are not Medicaid eligible and are in need of attendant services support. Copay is assessed after a monthly income of \$2199. A consumer must be 18 years or older, have the ability to manage their own attended care services, and is responsible for scheduling and timesheets. Consumers have the option to select from the CDS model or the provider service model. HHSC and DADS selects a CMPAS agency through the request for proposal (RFP) process every three to five years. The advantage of CMPAS is the ability to recruit, screen, interview, train, supervise attendants and substitute attendants as well as monitor and manage quality of service. Mr. Cranston provided a history of CDS and CMPAS stating it was the first program to serve under the vendor fiscal intermediary model. Barriers: One agency, no choice; low rates. Elizabeth Jones of DADS stated that CMPAS is regionally funded by Title XX and General Revenue funds. There are RFPs in catchment areas and bidding processes establish rates. Jonas Schwartz of DARS inquired about the CMPAS contract renewal cycle. CMPAS may have lost consumers to STAR PLUS. Ms. Crowther referred to the utilization report, titled *2015 - 2nd Quarter Compiled CDS Utilization Numbers* handout provided at the meeting quoting a CMPAS utilization rate at 19 percent.

Flora Brewer stated she ran a CMPAS program for four years and experienced one cycle of rebidding. She believes low CMPAS utilization resulted from poor advertising and low allocated funding. Ms. Brower stated it is a challenge for agencies to run CMPAS from a CDS basis but works well for consumers using the CDS option. The agency serves as the case manager and manages the annual assessment of needs, notifications, briefings, and financial evaluation of the program. These tasks would normally be performed under a CDS model by a case management agency but the CMPAS agency under the CDS model continues to perform these tasks but does not receive compensation. Rather, they only receive the FMSA fee, resulting in a time-consuming, labor intensive endeavor. FMSA needs assistance to run the CMPAS under the CDS model limited to one agency per region to perform these tasks. Elizabeth Jones reiterated CMPAS rates are negotiated regionally as part of the contracting process because it does not fall under Medicaid. Flora Brewer stated the compensation for CMPAS was over \$12.00 an hour several years ago and driven by DADS guidance. As a result of a complicated process and low funding, compensation is low. Ms. Crowther asked the members how to improve the CMPAS program by removing the barriers

for FMSAs and to make recommendations for areas of improvement. The intent of CMPAS is consumer-directed and consumer-managed. Historically, CMPAS is an original, federal and state prototype model for consumer direction.

Ms. Crowther referenced the *Texas Administrative Code, Title 40, Social Services and Assistance, Chapter 44, Consumer Managed Personal Attendant Services*, which describe the CMPAS program.

6. Public Comment.

The first public comment was made by Bob Kafka, Organizer with ADAPT Texas. Mr. Kafka discussed the \$7.86 an hour rate and recommended adding recruitment and retention as a standing committee of the CDW. It remains an ongoing challenge for consumers to find skilled, caring personal care attendants as the need for home and community based services expands. He expressed concern about the low statewide utilization of CDS. He highlighted two CDS systems 1) STAR PLUS and 2) the 1915(c) waivers.

The second public comment was made by Gene Whitten-Lege. He is a CMPAS provider and an original member of CDW. He highlighted the challenges for providers to manage CMPAS. The bidding of rates remains low at \$10 an hour for a length of five years. Ivy Goldstein, DSHS representative, stated CMPAS supports employment. Jonas Schwartz of DARS would like to have a discussion on managed care and how MCOs are paid and what process is used for CDS options at the next quarterly meeting.

Rebecca White, a CDW committee member, inquired about costs associated with CMPAS utilization, and hospitalization costs associated with low personal care attendant staffing. Agency staff was not sure there is sufficient data for this particular topic.

7. Reports from CDW members on Senate Bill 7 Advisory Committee - (Helen Baker, Ricky Broussard, and Linda Levine).

Mr. Broussard expressed concerns about transportation issues and asked to keep transportation when Community First Choice (CFC) becomes effective June 1. Ms. Levine expressed interest in establishing an employment plan subminimum wages with state contracts.

The State Medicaid Managed Care Advisory Committee met on April 29, 2015. The committee received a legislative update; a report on Medicaid managed care expansion; and a report on Community First Choice. They discussed recommendations they had made to the Executive Commissioner. Mr. Cranston identified a positive outcome from the 83rd legislative session resulted in the implementation of CFC which may lead to increased access to care as well as utilization of personal care attendants. Mr. Broussard stated the IDD Redesign advisory committee will be continued.

8. Discussion of Proposed Guidelines for the Subcommittee - Nancy Crowther

Kay Lambert, former CDW presiding officer, created the *Proposed Guidelines for the Subcommittee* document. Ms. Crowther opened the floor for recommendations and

highlighted the three standing committees: *Quality Improvement (QI)*; *Employer Support*; and *Service Expansion*. Mr. Cranston discussed the possibility of creating a recruitment and retention committee. Ms. Crowther would like to establish deadlines for subcommittee reports to be due to presiding officer and chair. One deadline discussed is to have subcommittees meet within one month after the quarterly meeting, and to submit a report and any recommendations to the presiding officer and chair within two weeks to allow a more thorough response. The committee will discuss establishing timelines, resignation process, and other guidelines via email.

9. Standing Committee Reports.

Ms. Levine inquired about the current subcommittee roster. Ms. Benedict will update and provide a subcommittee roster to the CDW.

Quality Improvement - Helen Baker. Some time was spent discussing network adequacy, centralized credentialing, service authorizations, and member access to service coordinators. A subcommittee is being formed to review and make recommendations to the workgroup on member access to service coordinators to improve communication processes. Regarding consumer direction, Ms. Baker indicated many service coordinators did not appear to know anything about consumer direction.

Employer Support - Nancy Crowther. The subcommittee recommended the development of a system to review and comment on correspondence sent to CDS employers on a trial basis to 1) ensure accurate translation of English to Spanish documentation, 2) ensure a system is in place to target the appropriate population, 3) work closely with translator(s) in translating documents from English to Spanish that affect CDS employers, and 4) make correspondence easier to understand.

Service Expansion - Linda Levine. The subcommittee recommended that CDS budgets create individualized budget options for all consumers for items and services needed on a personal basis determined by the person-centered plan which leads to person-centered delivery of services. This includes the purchase of goods and services that would increase independence. Examples include the purchase of a microwave to reduce the need to have an attendant prepare and serve meals, or a grocery delivery service; as well as home locks and lighting that can be controlled electronically. This recommendation will be forwarded to the workgroup. Mr. Cranston highlighted the subcommittee's recommendation that consumers of the CMPAS program be able to exercise their choice to use contracted FMSAs outside their designated service region. He also indicated the Legislative Appropriations Request (LAR) process regarding \$10/hr. wage. It was recommended to have the workgroup meet before the agencies begin submitting LARs in 2016.

10. Update on Community First Choice (CFC) in Managed Care - Chris Welch (HHSC) and Elizabeth Jones (DADS).

Elizabeth Jones introduced Chris Welch, CFC point person for Medicaid managed care. Ms. Jones gave a presentation on Community First Choice implementation effective June 1, 2015. CFC is a new Medicaid benefit allowing states to provide home and community-based services and supports to Medicaid recipients with disabilities under Section 1915(k) of the

Social Security Act. She provided detailed eligibility requirements as well as setting, support management, and emergency response services. Additionally, Ms. Jones presented on the provision of CFC compliance requirements and a provided a list of updated forms.

11. State Agency Reports (DADS, DARS, HHSC, TWC, DSHS)

DADS - Elizabeth Jones: Quarterly Technical Assistance webinars for FMSAs included CFC implementation. Revisions of the CDS employer manual were developed and will be posted on the DADS website soon to include the nursing toolkit. Employee Misconduct Registry automated phone line is no longer available. To conduct searches, she instructed individuals to use the DADS Employability Status Search online instead. The amended Department of Labor (DOL) home care rules were to become effective January 1, 2015. Two district court decisions vacated key parts of the amended rule and are on an expedited time line and the court should decide by the end of May or June. DOL invited states on a phone call to discuss the appeal. FMSA enrollment training is being held at the Travis Building from June 8-10th. A passing grade must be earned to become an FMSA.

Attendant base wage increase will be presented to the DADS Council on June 11, 2015 and Medical Care Advisory Committee on June 9, 2015. Mr. Broussard inquired about the opportunity to provide a bonus to staff. Ms. Jones stated it is accrued and built into the budget and is an option. Ms. Goldstein inquired about the CPR/choking/first aid requirements and training costs. CPR requirements were discussed among the different programs. MDCP permits online CPR training for certain programs. Concerns were expressed by the CDW about online CPR training.

HHSC highlights were previously discussed to include the attendant pay rates, the Sunset legislation, and the implementation of CFC.

DSHS - Dena Stoner: Agency progress includes the *Money Follows Persons* (MFP) demonstration project that provides specialized behavioral health services to Medicaid eligible adults with mental health or substance use disorders that have been institutionalized in nursing facilities and want to return to the community. Additionally, she indicated there are promising interim findings related to the *Wellness Incentives and Navigation* study designed to help improve health self-management. Another DSHS study, the *Self-directed Care* study concluded in 2012 and showed encouraging results. DSHS is developing plans with the Medicaid office and other stakeholders for a potential self-directed care pilot in Medicaid managed care. The *Youth Empowerment Services* (YES) waiver is expanding projected to occur sometime in 2016. Lastly, DSHS funds seven organizations in *Consumer Operated Service Providers*, peer-run providing peer support services.

Ms. Crowther thanked Ms. Stoner for bringing these issues to the CDW's attention. A copy of the study results and PowerPoint presentations will be provided by Ms. Stoner and disseminated to the workgroup.

DARS - Jonas Schwartz: All the services DARS provides have a self-directed element to them. Their employment services and independent living services are all directed by the

consumers themselves with the support of an independent living counselor or a vocational rehabilitation counselor. All of their services are short-term and time-limited but it is left to the individual consumer to state their employment or independent living goal. DARS provides guidance and support to consumers of the services in need. The Sunset process has made very significant changes to DARS to include the relocation of services currently provided under DARS into different state agencies. More information will become available at the next quarterly meeting.

Texas Workforce Commission representative was not present at the time the agency updates were provided.

12. Public Comment: No public comments were made.

13. Closing Remarks and Adjournment - Nancy Crowther.

Ms. Crowther thanked the workgroup members and visitors for attending the meeting. The next CDW meeting will be held Friday, July 24, 2015 from 10:00 a.m. to 3:00 p.m. at the Brown-Heatly Building, Public Hearing Rooms. Ms. Benedict provided the workgroup a meeting summary to include training opportunities, important dates, resources, and action items.

**Consumer Direction Workgroup
Regular Quarterly Meeting
10:00 a.m. - 3:00 p.m.
Brown Heatly Building, Room 1420-1430**

August 7, 2015

MINUTES

CDW Members Present:

Helen Baker
Flora Brewer
Ron Cranston
Nancy Crowther, Chair
Jennifer Farrar
Kristen Hebert
Kevin Jeffrey
Renee Lopez
Joshua Oyeniyi
Terri Stellar
Gyl Switzer

Agency Members:

Maria Benedict, Presiding Officer,
HHSC
Amanda Dillon, HHSC
Ivy Goldstein, DSHS
Elizabeth Jones, DADS
Racheal Kane, DSHS
Ginger Mayeaux, DADS
Jimmy Perez, HHSC
Jonas Schwartz, DARS
Dina Testoni, TWC

Guests:

Cathy Cranston, ADAPT
Anna DiCarlo, DADS
Rose Dunaway, Girling Healthcare
Denise Ellison, Coalition of
Texans w/ Disabilities
Joey Reed, HHSC
Pam Wright, HHSC
Gene Whitten-Lege, I-HAS
Pat Whitten-Lege, I-HAS
Caren Zysk, Molina Healthcare

Members Absent:

Ricky Broussard
Janet M. Brown
Leslie Curtis
Shelley Dumas
Linda Levine
Jackie Mason
Ramona Salomons
Sylvia Vargas
Rebecca White
Michelle Zadrozny

Committee Support Staff:

Sallie Allen, HHSC
Carmen Samilpa-Hernandez,
HHSC

1. Welcome, Introductions, and Announcements - Nancy Crowther

Nancy Crowther opened the meeting at 10:00 a.m. and welcomed guests. Self-introductions were made. Ms. Crowther announced the resignation of Ms. Marcela Patrick and Mr. David Ramos from the committee. She stated a quorum was not present.

2. Approval of Minutes (March 13, 2015 and May 2015 meetings)

Due to the lack of quorum, the minutes were tabled.

3. Health and Human Services Commission (HHSC) Legislative Update - Joey Reed

Mr. Reed referred members to the PowerPoint document in the meeting packet. He summarized the major provisions of Senate Bill 200 and presented the timeline for the HHSC transition plan. Mr. Reed stated that Legislative Oversight Committee membership appointments will be made by October 1, 2015, and encouraged interested members to reach out to the Governor's office in regards to the formation of the committee membership. He reported 38 of the roughly estimated 132 advisory committees will be removed from statute. The plan is to complete an initial assessment of advisory committees by the beginning of September 2015, solicit public input during September and October, and develop and publish the list of new advisory committees in the *Texas Register* on November 1, 2015.

Ron Cranston asked if legislative appropriations were given for the cost of streaming advisory committee meetings. Mr. Reed said that the Bill requires committee meetings to be streamed, but does not provide funding for the streaming; to date, a funding source hasn't been explored. In regards to the Legislative Oversight Committee, Mr. Cranston asked if there is a way to ensure continuity of the committee activities in the process of transitioning out and in advisory committees. He responded that public meetings will be held throughout the process of structuring the transition plan for the reorganization of the health and human services system. A member asked what is the duration of the committee. Mr. Reed stated that the Legislative Oversight Committee will be abolished in 2023. Flora Brewer asked what expertise is being brought in to assist with the transition and its budget. She also asked if funding for client services will be adversely impacted due to the funding of transition activities. He stated that he could not estimate an amount. In regards to the expertise, HHS is looking at utilizing in-house staff as well as outsourced assistance with the transition process. Ms. Brewer said that the workgroup previously submitted a letter to HHSC requesting that the CDW continue as a workgroup/committee and asked if another letter needed to be provided. Mr. Reed encouraged the workgroup to submit a letter to HHSC and to utilize the public hearings to convey the workgroup's message. He stated that the structure for the public comment process will be shared with the committees. In regards to the state's response to public comment, Brewer suggested that written response should be provided even when the State has no response to the comment. Mr. Reed stated he will take this comment to his group. He further stated that he will provide Maria Benedict a point of contact at the Governor's office regarding the Legislative Oversight Committee membership appointments and he will provide clarification on the meeting status of the Legislative Oversight Committee meetings in regards to its requirement to follow the Open Meetings Act rules. A member asked if final reports will be requested from the advisory committees being abolished. Mr. Reed said he will make note of the question. Nancy Crowther asked if the process will be made in alternative languages. He said he'd take this comment back to his group as well. Maria Benedict stated HHSC will continue to provide support, guidance and communication to the CDW members. CDW issues will continue to move forward and activities will be coordinated. Noting a member's absence today due to unavailability of travel funds, Ron Cranston asked about the status of travel reimbursement for CDW members. Ms. Benedict said travel funding has been traditionally provided by the University of Texas; however HHSC is exploring the possibility of providing travel reimbursement for the CDW effective September 2015. Ms. Benedict asked Mr. Reed to provide clarification of the terms "removed" and "abolished". He explained that S.B. 200 removes references to 38 HHS advisory committees in statute and directs the agency to determine what committees need to be re-established. Abolishing a committee from statute doesn't mean the committee is going away because the agency can recreate the body. She asked if

the committees will be notified of their final status before the Executive Commissioner's decision is posted in November. He stated that committee member and public input along with other information will be used by the Executive Commissioner to make decisions. She asked if current membership terms ending December 31, 2015, will be suspended. He said the response to the question depends on which committees are continuing and not continuing as that will impact how the membership terms will be affected. He noted the inquiry and stated a response would be provided. Mr. Jeffrey suggested members attend the transition meetings to keep abreast on current activities. Nancy Crowther thanked Mr. Reed for his presentation.

4. Chair Report - Nancy Crowther

Nancy Crowther directed members and guests to the ADAPT of Texas/Personal Attendant Coalition of Texas (PACT) recruitment and retention campaign document in the meeting packet and stated that public comment related to the campaign will be heard at this time. She stated that at a previous CDW meeting, members agreed to add recruitment and retention of attendants as a priority standing item on each of the CDW subcommittee agendas.

PUBLIC COMMENT

Cathy Cranston, ADAPT of Texas/PACT: Ms. Cranston referred to the document which outlined campaign strategies and tactics. She expressed her appreciation to the workgroup for their support and requested that they continue providing the much needed support. Ms. Cranston went on to share the personal stories of two CDW consumers, Mr. Cundall of Austin, Texas and Mr. Lara of El Paso, Texas. Copies of their stories were provided to CDW support staff for distribution.. She spoke how services without unnecessary barriers and wage enhancement for a strong workforce are needed.

Ms. Benedict reported that the 2015-16 General Appropriations Act (*H.B. 1, 84th Legislature, Regular Session, 2015, Article II, HHSC, Rider 89*), directs HHSC to develop strategies for recruitment and retention of community attendants to address the projected shortage of attendants. Ms. Benedict noted that HHSC and DADS are working collaboratively in outreaching stakeholders with details on the agency's response to Rider 89 activities and that an implementation plan have not been set. Ms. Crowther made the executive decision to move the ADAPT of Texas/PACT document forward to HHSC Executive Commissioner Chris Traylor. The work of the subcommittees has been valuable and addressed difficult issues. In regards to upcoming projects, members will be asked what subcommittee workgroup they would like to serve on.

5. Approval of Subcommittee Recommendations - Nancy Crowther

Due to the lack of quorum, the subcommittee recommendations were tabled.

6. Presiding Officer Report - Maria Benedict, HHSC

Maria Benedict talked about the action items from the May 29, 2015 meeting. She reported that all action items have been fulfilled. Nancy Crowther thanked Ms. Benedict for the weekly updates which are informative. Ms. Benedict said the weekly communications are an opportunity for consumers and general public members to exchange ideas and share information. Ms. Benedict welcomes feedback for the weekly communication e-mail content.

7. Managed Care Organizations' (MCOs') Payment Option Discussion and Presentation - Amanda Dillon, HHSC

A PowerPoint document entitled "Overview of Consumer Direct Services in STAR+PLUS" was provided in the meeting packet. Ms. Dillon reported that STAR+PLUS became available statewide on September 1, 2014, and as of April 2015, there were 577,399 individuals currently enrolled. She provided details about service coordination and the three levels of service coordination that are based on an individual's need. She went on to state that Section 8.3.2 of the Uniform Managed Care Contract (UMCC) outlines the service coordination requirements that the MCOs must comply with and the UMCC is available on HHSC's website. She went over the three Long Term Support Services (LTSS) delivery options, the LTSS services available, and the relationship between the MCOs and their providers. Ms. Dillon provided the HHSC Managed Care website address and the HHSC Health Plan Management (HPM) e-mail address: hpm_complaints@hhsc.state.tx.us. She stated one benefit of being in managed care is that if a provider or member has a complaint or issue, they can take it directly to the MCO. If the MCO is unable to resolve the issue, the individual has the option to take the concern to the HHSC HPM division who will assist the individual with the issue. Referring to the PowerPoint document, Helen Baker asked for clarification about the Service Responsibility Option (SRO) description of the member managing most day-to-day activities and the MCO managing all business details. Ms. Dillon responded that the MCO can perform the functions or contract the functions to a HCSSA. Ron Cranston asked if an individual will automatically get a service coordinator and will the individual automatically receive a level once they are assessed. She explained that the level is not based on the assessment, but on the needs of the individual. There was discussion about the definition of clean claims and the untimely process of clean claims being reported in the provider community. Authorization and payment timeframes were also discussed. Kevin Jeffery said these issues are directly impacting individuals enrolled in the program and recommended that HHSC should be more involved in this conversation due to the effect on the clients. Mr. Cranston reported that payment issues are occurring in the traditional model as well as in the CDS model. If the agencies cannot make payroll, it negatively impacts the participants.. Ms. Dillon suggested contacting the MCO provider relations department for assistance with getting claims processed quicker and she also encouraged participation in advisory committees which discuss topics related to the MCOs. She will take these concerns to the next meeting of the standing workgroup with MCOs and encouraged members to use the HPM complaint line to voice issues so that HHSC can address the issues and impose punitive actions where warranted. Mr. Cranston asked how long an MCO has to authorize services and change an ISP. She stated she will provide the ISP timeframe information to Maria Benedict for the workgroup. Helen Baker remarked that a delay in service hour changes could be a result of the service coordinator actions, rather than the MCO actions. The participant could contact the HHSC Ombudsman office for a quick response. Flora Brewer asked if the HHSC has set benchmarks for MCOs to reach in regards to enrolling individuals into CDS. Ms. Dillon stated there were no benchmarks, however the agency sets education requirements and has a CDS training for MCOs. Joshua Oyeniyi asked if MCO had the option to not contract with FMSAs. She said yes, as long as the MCO provides a sufficient managed care network of providers for the client to choose from. Mr. Oyeniyi directed a question to DADS staff and asked why DADS conducts FMSA classes on a regular basis when the MCOs say they have enough FMSAs. Elizabeth Jones responded that the 1915(c) waiver funding mechanism mandates that Texas offer open enrollment for FMSAs. He asked if there was a requirement to onboard a certain number of FMSAs. Ms. Jones answered

that CMS is not requiring a certain number, but is requiring that HHSC have an open enrollment throughout the year. She said that the state is interested in receiving comment and suggestions on this topic. Jonas Schwartz expressed appreciation to Amanda Dillon for her informative presentation. She announced that the Service Coordination Workgroup will reconvene to discuss service coordination requirements. Ms. Dillon requested members to e-mail two to three recommendations on items they'd like to see strengthened, omitted or remain the same in service coordination to Maria Benedict by COB Friday, August 14th. The hyperlink to UCCM 8.3.2 listing the service coordination requirements as well as a one-page summary on service coordination will be provided to the workgroup. Ms. Goldstein shared that as a parent to a STAR+PLUS member, she didn't know service coordination existed for her child. She would like to see more communication and education shared with members and their families. Amanda Dillon asked Ms. Goldstein to send her comment to Maria Benedict for further review. Members continued to discuss consumer education and communication between the MCO and consumers regarding point of contacts. Joshua Oyeniyi asked questions about the various MCOs having different rates and budget workbooks. He also asked about billing MCOs for incidentals such as taxes and workbooks. Ms. Dillon stated that billing for taxes, workbooks and etc. is a concern brought up by other providers and reported that HHSC is exploring options with what it can do to uniform the way budgets/workbooks are done. The workgroup activities and direction will be reported back to the workgroup.

8. **Public Comment** - addressed under agenda item 4.
9. **Lunch** - The workgroup adjourned for lunch at 12:20 p.m.

The following agenda items changed order on the agenda.

11. Consumer Directed Services Rules Update - Elizabeth Jones, Department of Aging and Disability Services (DADS)

A presentation of the document entitled " DADS Proposed Rules Summary: Community First Choice (CFC) in DADS ICF/IID Waiver Programs" was given by Elizabeth Jones. Copies of the document were given to members and guests. She encouraged members to review and provide comment on the rules by August 12, 2015, which is the end of the informal public comment period. Ms. Jones invited questions on the proposed rules from the workgroup.

Jennifer Farrar asked if transportation will be a new service added to the front of the plan or will it be billed back under community support/supported home living. Ms. Jones explained that they are in the process of finalizing information letters which will explain how implementation, service code authorization, and billing. The letters will be posted for stakeholder input in the next several weeks. She encouraged members to review and provide feedback at that time. Joshua Oyeniyi asked who would be responsible for paying the fee for running a criminal background check if the consumer only has CFC PAS/HAB. Ms. Jones responded that the FMSA is responsible for paying for criminal history checks on these individuals. He asked who in the home could provide CFC PAS/HAB and he asked about a designated representative (DR) living in the home providing services. Ms. Jones stated that the decision of having a DR is left up to the employer, unless it was raised at the initial assessment/self-assessment that indicated a DR was required. She went on to explain that for CFC rules, the individual providing PAS/HAB may be someone living in the same residence and went on to list who could and could not provide services in regards to the proposed CFC rules as well as the

current CDS rules. Helen Baker stated that there are service coordinators directing services incorrectly in regards to DR. She has seen this direction within the Local Intellectual and Developmental Disability Authority and recommends this topic be clarified with them. She thanked Ms. Baker for the comment. Mr. Oyeniyi asked if the monthly FMSA fee could not be paid from PAS/HAB if the individual has other services. Ms. Jones explained that the monthly FMSA fee will be received regardless of PAS/HAB being the only service or not. She continued by saying the issue is regarding if the service is billed to regular FMS or CFC FMS and explained the difference between the two.

13. State Agency Reports, Part 1 of 2

Michael Roberts, Department of Family Protective Services (DFPS)

For CDS, the idea behind S.B. 1880 is protection for CDS participants by moving investigations from the Investigations In-home section to the Adult Protective Services (APS) Facility Program, which will undergo a name change to APS Provider/Facility Program to better encompass what the program will cover. He directed members to the handout in the meeting packet entitled "SB 1880/SB 760 - APS Authority To Investigate" noting that both bills are stated due to both bills passing, however S.B. 1880 is usually how the mandated changes are referred to. DFPS is working with HHSC, DADS and DSHS to see how to operationalize the new authority. He presented the document entitled "APS Provider/Facility Investigations Program" and explained the investigations process as well as the provider/facility rights and responsibilities. One element he pointed out was that up until this bill, investigation of children as the recipient of services was not mandated. Maria Benedict asked if the state will be conducting trainings. Elizabeth Jones said that trainings will be scheduled and the draft information letters will be shared with the workgroup prior to going out.

Ginger Mayeaux and Elizabeth Jones, DADS

Ms. Mayeaux highlighted dates and activities from the document entitled "Consumer Direction Workgroup (CDW) Update August 2015". In regards to TxHmL and HCS, Jennifer Farrar asked if CDS participants will be required to enter data into the CARES system. Elizabeth Jones said the state is working on this part. She noted that since CDS consumers are not HCSSAs and not certified providers, reporting requirements will be different. Joshua Oyeniyi asked questions about communication requirements between the FMS and DFPS APS. Elizabeth Jones said that the state is actively looking at this piece and noted that case managers and service coordinators have a role in this as well.

Ron Cranston shared this investigative process complicates the access point of reporting ANE. This is a mandated directive, but recalls the intention was initially focused on IDD. Michael Roberts affirmed that the intake process for ANE reporting remains the same, the place it goes within DFPS, the investigation processes followed, and the end product will change. Mr. Cranston feels like this change fragments the current system. Ms. Jones said this is excellent feedback and needed this for the stakeholder review process. The main concern is health and safety. The state does not anticipate the CDS employer entering data into a state data system. Maria Benedict stated each allegation will receive the same type of investigation. Michael Roberts stated that was correct. Kristen Hebert asked for the investigation process timeframe. He stated that the current timeframe is usually 14 days and the new rule is that investigations can be 21 days. He noted that DFPS data shows an average investigation process is between 10- 14 days. In regards to Elizabeth Jones' comment on the investigations process, Kristen Hebert shared that her experience with investigation is that they are conducted through HR and an IDT meeting may not be best option for each ANE report due to

privacy issues. She requested to see education in this area. Ms. Mayeaux responded that the ANE report could be addressed in a limited IDT meeting. She noted that that this process is being explored.

10. Electronic Visit Verification Update - Deborah Keyser, HHSC

Deborah Keyser stated Electronic Visit Verification (EVV) has been implemented statewide as of June 1, 2015. There are three vendors which have three different systems. One of the biggest issues heard from providers is the receipt of small alternative devices from vendors to place in homes where a landline is not available. Providers are reporting that visit maintenance in the EVV systems is very time consuming. Due to system issues providers are encountering, the state is allowing for the 21 day visit maintenance requirement period to be suspended until August 31, 2015, which allows providers to perform visit maintenance at any time during the implementation grace period. Although system issues have been encountered by some providers, all providers should be fully using the EVV system by September 1, 2015. During the implementation grace period, providers experiencing system issues can use paper timesheets for visit verification. HHSC developed a provider survey for EVV; the link to the survey has been posted on the TMHP website as well as on the five MCO websites. Provider trainings for EVV were conducted in March, April, June and July 2015. All training materials are posted on the DADS EVV website. She also reported that vendors are experiencing data integrity issues due to providers leaving required fields blank in the EVV system. HHSC issued a notification to providers to ensure providers are entering all required fields in the EVV system. She provided the new contact information for EVV general questions and complaints: electronic_visit_verification@hhsc.state.tx.us and DADS.evv@dads.state.tx.us. TMHP and all five MCOs can be contacted as well; all contact information for EVV is listed on all of the provider notifications posted for EVV. She stated that if the provider is experiencing EVV system issues, the EVV vendor should be contacted directly. Nancy Crowther asked if additional components can be purchased by the agency to make the system easier to use. Ms. Keyser said yes. There is no cost to providers for EVV, however if additional items outside the scope of the HHSC EVV initiative are purchased, the provider agency will be responsible for those costs. Ms. Crowther asked if there is a window of time an attendant has to clock in and clock out. She said there is a two-hour window before the scheduled start time and end time, equaling four hours total. The four hour window has been discussed with the three vendors and set up in each system to ensure uniformity. Ms. Crowther asked if agencies will be penalized for performing visit maintenance after September 1, 2015. Ms. Keyser stated that visit maintenance will continue to be part of EVV. Ms. Crowther asked about ADA compliance requirements and the visit maintenance system in regards to the MEDsys system; Ms. Crowther has one employer with ADA-related issues. Ms. Keyser stated that having accessible systems is a standard requirement for the EVV vendors and asked Ms. Crowther to submit the issue to the EVV mailbox. Joshua Oyeniyi asked questions about situations where an attendant is clocking in and clocking out above the authorized hours. The state is putting employers in a position due to the EVV log in/log out system since the employer can only bill what is authorized. Ms. Keyser indicated that the EVV system is an electronic form of a paper timesheet, and should not be any different regarding authorized hours and the amount of time for services provided as was before EVV was implemented; she recommended that questions regarding authorized hours be directed to a provider's payer. Mr. Oyeniyi said that with paper timesheets, this was not an issue. She indicated that the service delivery time can be adjusted through visit maintenance. He stated that the visit maintenance can edit the time in the system, but the issue remains. Flora Brewer asked if there are any cost savings at HHSC due to EVV. Ms. Keyser said

that cost savings aren't yet known as there is insufficient data at this time. Expectations are that there will be cost savings as the DADS pilot study data showed a 4% to 5% savings to the state. Maria Benedict said she sent the DADS cost savings data to the workgroup on June 3, 2015 via e-mail. Ron Cranston said that it would be beneficial to capture data showing the costs for agencies. It appears to be more of a cost shift than a cost savings based on what he's hearing in the community. Helen Baker reported that she has seen over \$500,000 in costs due to using the EVV system. Three workgroup members echoed Helen Baker. Ms. Baker ended by stating that competing rules regarding paying attendants make it difficult to implement EVV. Ms. Keyser said she would note the comments. Maria Benedict thanked Ms. Keyser for the update and asked her to provide an update at the October 2015 meeting.

Before moving on to the next agenda item, Ms. Crowther turned the workgroup's attention to the third quarter utilization numbers which were shared with members. There was no discussion.

12. Sub-Committee Update Status Reports

- a. Employer Support – No report.
- b. Quality Improvement - Helen Baker reported that the sub-committee had not met since the last CDW meeting. They participated in a six-member panel presentation at an FMSA training. The sub-committee plans to meet in August and prior to the CDW October 2015 meeting. Ms. Crowther thanked Ms. Baker for the update.
- c. Service Expansion - No report.

Flora Brewer expressed her concern with the CMPAS program recommendation to have choice in selecting their FMSA. The recommendation does not address the case management task and payment issue. The workgroup discussed the concern and Title XX funding. Elizabeth Jones suggested the workgroup request a Title XX program representative to speak on the funding topic. Ron Cranston asked if Title XX funds have diminished over the years. Ms. Jones stated she will obtain a response to this question.

On behalf of Janet Brown, Helen Baker announced that the proposal presented to the State Association of Social Workers was accepted and they will be speaking on Consumer Direction at their October 2015 meeting in Galveston, Texas. Ms. Crowther thanked Ms. Baker and Ms. Brown for making that happen.

13. State Agency Reports. Each State Agency Will Provide an Update, Part 2 of 2

- a. DADS - Ginger Mayeaux thanked CDW members for speaking at the FMSA Open Enrollment Training. She felt it was one of the most beneficial portions of the training. She directed members to Item 13, handout 2 of the meeting packet and announced the upcoming trainings and meetings. Elizabeth Jones went over the attendant base wage increase and shared the implementation schedule of the new rules effective September 1, 2015. A member noted that the GovDelivery notice stated that the home health rates were effective November 1, 2015. Ms. Jones said she will look into that information and provide any necessary corrections. Ron Cranston asked if rate enhancements were bumped up. Ms. Jones said that rate enhancements for provider delivered services was bumped up effective September 1, 2015 and the schedule is stated on the rate memo.

- b. Department of Assistive and Rehabilitative Services (DARS) - Jonas Schwartz was not available to provide the report; however he provided copies of an update to the workgroup and guests. Nancy Crowther suggested members contact Mr. Schwartz with any questions regarding the DARS update.
- c. Department of State Health Services (DSHS) - Ms. Kane directed members to Item 13, handout 4 of the meeting packet. She reviewed the document with members. She reported that DSHS received a second SAMHSA grant approval this morning. The grant will allow the agency to continue background research on the original SDC research project in the Dallas area. DSHS will specifically look at future research methodology and operational guidelines.
- d. HHSC agency report - Amanda Dillon reported that HHSC is reviewing the CMS bulletin on housing in coordination with Office of Policy and will direct questions to CMS during a CMS technical call scheduled for later this month. Upcoming HHSC meetings dates were given.
- e. Texas Workforce Commission – no report.

14. Public Comment

Nancy Crowther asked for comment. There was none.

15. Closing Remarks - Nancy Crowther

Ms. Crowther reminded everyone that the next meeting is scheduled for October 23, 2015. She will keep everyone abreast of legislation decisions impacting the planned CDW 2015 schedule and encouraged new members to contact her directly if they have any questions or concerns. Ms. Crowther thanked everyone for their time and dedication to the workgroup. Kevin Jeffrey asked for HHSC's address on the topic of MCOs and the way they are funded in the CDS option be included as an action item for the October 23rd meeting. Ms. Crowther adjourned the meeting at 3:13 p.m.

**Consumer Direction Workgroup
Regular Quarterly Meeting
10:00 a.m. - 3:00 p.m.
Brown Heatly Building, Room 1420-1430**

October 23, 2015

MINUTES

CDW Members Present:

Ricky Broussard
Ron Cranston
Nancy Crowther, Chair
Leslie Curtis
Kristen Hebert
Kevin Jeffrey
Linda Levine
Renee Lopez
Jackie Mason
Gyl Switzer
Michelle Zadrozny

Agency Members:

Maria Benedict, Presiding Officer,
HHSC
Amanda Dillon, HHSC
Ivy Goldstein, DSHS
Elizabeth Jones, DADS
Ginger Mayeaux, DADS
Jimmy Perez, HHSC
Dina Testoni, TWC

Guests:

Megan Morgan, The Arc of Texas
Rose Dunaway, Kindred at Home
Donna Parker, Central Texas
Aging and Disabled Veterans
Resource Center
Gene Whitten-Lege, I-HAS
Pat Whitten-Lege, I-HAS
Caren Zysk, Molina Healthcare
Joseph Cook, Outreach Health
Services
Anna DiCarlo, DADS
Jennifer Chancellor, DADS

**CDW Members Present:
(via phone)**

Helen Baker

Committee Support Staff:

Sallie Allen, HHSC
Carmen Samilpa-Hernandez,
HHSC

Members Absent:

Flora Brewer
Shelley Dumas
Jennifer Farrar
Joshua Oyeniyi
Ramona Salomons
Terri Stellar
Sylvia Vargas
Rebecca White

1. Welcome and introductions- Nancy Crowther

Nancy Crowther called the meeting to order at 10:00 a.m. and welcomed guests. Self-introductions were made. A quorum was present at 10:10 a.m.

2. Approval of Minutes (March 13, 2015, May 29, 2015, and August 7, 2015 meetings)

March 13, 2015 minutes

A motion to approve the March 13, 2015 minutes was made and the motion passed unanimously.

May 29, 2015

A motion to approve the May 29, 2015 minutes was made and the motion passed unanimously.

August 7, 2015

A motion to approve the August 7, 2015 minutes was made. All members were in favor with the exception of Ricky Broussard who abstained from voting.

3. Chair report on workgroup-related activities since the last meeting.

Ms. Crowther provided a brief review of the 84th Legislative session's impact on consumer direction support services. She directed the group to the CDW Utilization Review data provided in the meeting packet. There was no discussion.

4. Presiding Officer report on workgroup-related activities since the last meeting.

At the request of Maria Benedict, Ron Cranston provided a summary of the October 2015 PACT Attendant of the Year Award Ceremony activities. Ms. Benedict thanked Mr. Cranston for the information. There was discussion regarding the electronic weekly update. Mr. Cranston requested a larger font size for the text in the tables. Mr. Broussard asked that a consolidated report of the updates be provided at future meetings.

5. Public Comment

Public comments were heard under agenda item 10.

7. Approval of sub-committee recommendations (Vote required.)

a. Employer Support, CDS option

Leslie Curtis presented the employer support recommendation. There were no questions or comments. The motion to approve the recommendation passed unanimously.

b. 1. Quality Improvement, CDS service delivery option

Helen Baker presented the recommendation to the workgroup. DADS Information Letter No. 09-153, Personal Care Services and Waiver Services was referenced. Mr. Broussard said time should be allotted for the consumer to comprehend, review, and ask questions about the form and the case manager should take time to explain the form to the consumer. The motion to approve the recommendation passed unanimously.

2. Quality Improvement, In-home respite rate

Ms. Baker presented the recommendation to the workgroup. Mr. Broussard stated rates should be looked at across the board. The motion to approve the recommendation passed with no objections.

3. Quality Improvement, Personal Care Services rate

Ms. Baker presented the recommendation to the workgroup. Kevin Jeffrey asked if the impact of recent U.S. Department of Labor (DOL) law definition revisions could be added to recommendation. The DOL definition changes regarding time and a half for companion care adds a challenging impact on the services on top of cost of living not being increased. Ron Cranston said he supported the recommendation and suggested that rate increases be addressed across the board in future rate increase recommendations. There was discussion about the recent DOL definition changes regarding earned bonuses, time and a half pay, and joint employment. Elizabeth Jones explained that consumers will continue to identify

bonuses in the budget workbook. Discussion about bonus definitions and budget planning continued. The motion to approve the recommendation passed with no objections.

c. 1. Service Expansion, Choice in Consumer Managed Personal Attendant Services program

Ron Cranston presented the item to the workgroup. The motion to approve the recommendation passed with no objections.

2. Service Expansion, CDS service delivery option

Linda Levine presented the recommendation to the workgroup. The motion to approve the recommendation passed with no objections.

Ms. Crowther thanked the subcommittee members for their dedication and effort to the subcommittee goals. Maria Benedict said she would work with DADS to develop a timeline for the approved recommendations. Ms. Levine asked if stakeholders will participate in the development process. Ms. Benedict responded that the process would be a joint effort with stakeholders.

10. Public comment

Nancy Crowther, Austin, Texas: Ms. Crowther commented on the difficulties she's experienced and seen with the Electronic Visit Verification (EVV) system. She recommends that the Commission extend the current audit timeframe of 21 days be extended to 60 days to allow sufficient time for small and/or nonprofit agencies to perform correction and evaluations. Additionally, Ms. Crowther wants to see HHSC and DADS cost savings reports. Many agencies are hiring EVV system coordinators and/or adding duties onto existing staff workload due to the EVV system. Ms. Crowther said accountability and user friendliness are areas the HHSC needs to address for employers and consumers in regards to the EVV system.

Amy Litzinger, Austin, Texas: Ms. Crowther read Ms. Litzinger's written comment about the current travel rule regarding leaving the state. The written comment was shared with workgroup members.

Ricky Broussard, Texas City, Texas: Mr. Broussard stated that he agrees with Ms. Litzinger's comment.

9. State agency reports

Amanda Dillon, HHSC, gave a brief update on managed care activities within the agency. Service coordinators training regarding consumer direction has been a top goal. With the assistance of Helen Baker, a training document was put together which is pending agency approval. Once approval is received, the document will be published in the Star Plus handbook and the document will be available on the internet. A link will be shared with the workgroup.

6. Lunch (recess)

The workgroup adjourned for lunch at 11:28 a.m.

8. Sub-committee update status reports

a. Employer Support

No report was given.

b. Quality Improvement

The October 14, 2015 Quality Improvement committee meeting minutes were shared with the workgroup. There were no questions.

c. Service Expansion

Leslie Curtis shared the October 14, 2015 teleconference notes with the workgroup.

Michelle Zadrozny shared the Central Texas Home Care Coalition's efforts regarding care attendant training and care attendant retention. She shared the Coalition's current survey data with the workgroup regarding pay rates. Maria Benedict will share a link to the data with the workgroup.

9. State agency reports

a. Department of Aging and Disability Services (DADS)

Copies of the DADS CDW update document were given to members. Ginger Mayeaux reviewed the highlights of the document. She announced that the agency would be building a consumer direction services employer panel in the near future. Ms. Mayeaux invited consumer direction services employers to contact her if they are interested in participating on the panel.

Elizabeth Jones introduced DADS staff Jennifer Chancellor and Anna DiCarlo. She said the department's Abuse, Neglect and Exploitation letter will be redrafted and opened up to receive comment. Ms. Jones stated that CDS employers can participate in the process. Ms. Jones provided clarification on out of state travel in regards to the CDS option and the public testimony received today. She said individuals on CDS can travel out of state across the programs. The issues are with CLASS and DBMD rules, suspension of services can be imposed if you go out of state. The rules should state that it only pertains to provider delivered services. Due to this error, an information letter was sent out to clarify this issue. She thanked Ms. Litzinger for bringing this issue up for public comment today.

b. Department of State Health Services (DSHS)

Copies of the DSHS CDW update were shared with the workgroup and public members. Ms. Rachel Kane talked about the update and said a link to a webinar *Making Self-Directed Care a Reality* will be shared with Ms. Benedict for the workgroup.

c. Health and Human Services Commission (HHSC)

Copies of the HHSC CDW update were provided to members. Jimmy Perez provided a summary of the Home and Community based Services rules. Mr. Perez said that Texas has until March 2019 to fully comply with the new rules. There was discussion regarding the external assessments, specifically the site visits and participant surveys. Gyl Switzer commented on the 1915(i) adult mental health benefit status and said that it would be beneficial to webcast the stakeholder forums. Discussion of webcasting public forums continued.

d. Department of Assistive and Rehabilitative Services (DARS)

Copies of the DARS CDW report was shared with workgroup and the public members. There was no discussion.

11. Closing Remarks - Nancy Crowther

Ms. Crowther thanked everyone for their time and commitment to the workgroup and consumer directed services. Ron Cranston thanked Ms. Crowther for her leadership and Ms. Benedict for her communication updates. Ms. Crowther adjourned the meeting at 2p.m.

DRAFT

ASSESSMENT OF ADVISORY COMMITTEES
April, 2016
529 - Health and Human Services Commission

To assist in the process required by Chapter 2110, Texas Government Code, state agencies should submit an assessment of advisory committees using the format provided. Please submit your assessment for each advisory committee under your agency's purview. Include responses for committees created through statute, administrative code or ad-hoc by your agency. Include responses for all committees, whether ongoing or inactive and regardless of whether you receive appropriations to support the committee. Committees already scheduled for abolishment within the 2016-17 biennium are omitted from the scope of this survey. When submitting information for multiple advisory committees, right-click the sheet "Cmte1", select Move or Copy, select Create a copy and move to end.

NOTE: Only the items in blue are required for inactive committees.

SECTION A: INFORMATION SUBMITTED THROUGH ADVISORY COMMITTEE SUPPORTING SCHEDULE IN LEGISLATIVE APPROPRIATIONS REQUEST

Committee Name:	Value Based Payment and Quality Improvement Advisory Committee		
Number of Members:	15		
Committee Status (Ongoing or Inactive):	Ongoing	Note: An Inactive committee is a committee that was created prior to the 2014-15 biennium but did not meet or supply advice to an agency during that time period.	
Date Created:	Est.: 7/1/2016	Date to Be Abolished:	7/1/2020
Budget Strategy (Strategies) (e.g. 1-2-4)	A.1.1	Strategy Title (e.g. Occupational Licensing)	Strategic Engagement
Budget Strategy (Strategies)		Strategy Title	

State / Federal Authority
State Authority
State Authority

State Authority
Federal Authority
Federal Authority
Federal Authority

Select Type	Identify Specific Citation
Statute	Texas Government Code §531.012
Admin Code	Sec. 351.821 (Final adoption est. July 1, 2016)

Advisory Committee Costs: This section includes reimbursements for committee member costs and costs attributable to agency staff support.

Committee Members' <u>Direct</u> Expenses	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$0
Number of FTEs	0.0	0.0	0.0
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$0

Committee Members' <u>Indirect</u> Expenses	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Travel	\$0	\$0	\$0
Personnel	\$0	\$0	\$28,000
Number of FTEs	0.0	0.0	0.4
Other Operating Costs	\$0	\$0	\$0
<i>Total, Committee Expenditures</i>	\$0	\$0	\$28,000

Method of Financing	Expended	Estimated	Budgeted
	Exp 2015	Est 2016	Bud 2017
Method of Finance			
1 - General Revenue Fund	\$0	\$0	\$0
758 - GR Match for Medicaid	\$0	\$0	\$28,000
	\$0	\$0	\$0
	\$0	\$0	\$0
	\$0	\$0	\$0
Expenses / MOFs Difference:	\$0	\$0	\$0

Meetings Per Fiscal Year	0	0	4
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Committee Description: The Quality Committee provides a forum to promote public-private, multi-stakeholder collaboration in support of quality improvement and value-based payment initiatives for Medicaid, other publicly funded health services, and the wider health care system. The committee will provide stakeholder input and subject matter expertise to assist HHSC with the development of strategies, projects, and metrics to pursue better care, better outcomes, and lower costs in its programs.

SECTION B: ADDITIONAL COMMITTEE INFORMATION

Committee Bylaws: Please provide a copy of the committee's current bylaws and most recent meeting minutes as part of your submission. Note: this committee has not met and does not yet have bylaws or meeting minutes.

1. When and where does this committee typically meet and is there any requirement as to the frequency of committee meetings?

The committee is expected to meet four times each year at the HHSC Brown Heatly Public Hearing Room in Austin Texas.

2. What kinds of deliverables or tangible output does the committee produce? If there are documents the committee is required to produce for your agency or the general public, please supply the most recent iterations of those.

This is a new committee that has not yet completed a deliverable. The Quality Committee will produce a biennial policy report to the Legislature and the Executive Commissioner that describes current trends and identifies best practices in health care for value-based payment and quality improvement and provides consensus recommendations for improving quality and efficiency in Texas health care related programs.

3. What recommendations or advice has the committee most recently supplied to your agency? Of these, which were adopted by your agency and what was the rationale behind not adopting certain recommendations, if this occurred?

This is a new committee that has not yet met.

4a. Does your agency believe that the actions and scope of committee work is consistent with their authority as defined in its enabling statute and relevant to the ongoing mission of your agency ?

Yes

4b. Is committee scope and work conducted redundant with other functions of other state agencies or advisory committees?

No

5a. Approximately how much staff time (in hours) was used to support the committee in fiscal year 2015?

0.0

5b. Please supply a general overview of the tasks entailed in agency staff assistance provided to the committee.

The committee has not yet met; however, staff estimate that it will provide logistical support, facilitation, and documentation for all meetings; perform research and coordinate/produce analytics on behalf of the committee; draft policy and related reports; manage/coordinate other deliverables originated by the committee; and coordinate planning discussions via webinar, in-person, or teleconference involving subject matter experts and work group leads. Staff will also coordinate the recruitment of members.

6. Have there been instances where the committee was unable to meet because a quorum was not present?

No

Please provide committee member attendance records for their last three meetings, if not already captured in meeting minutes. (The committee has not yet met).

7a. What opportunities does the committee provide for public attendance, participation, and how is this information conveyed to the public (e.g. online calendar of events, notices posted in Texas Register, etc.)?

Meetings will be open to the public and opportunity for public comment will be provided for each meeting topic and at a designated time during each meeting. The public may also submit comments in writing to staff supporting the committee. Meetings will offer opportunities for stakeholders to provide invited presentations and serve as subject matter experts. Notices for meetings and other key milestones will be distributed to stakeholders via a program distribution list. Meetings will also posted to the Texas Register in compliance with Texas Open

7b. Do members of the public attend at least 50 percent of all committee meetings?

Yes

7c. Are there instances where no members of the public attended meetings?

No

8. Please list any external stakeholders you recommend we contact regarding this committee.

Texas Medical Association, Texas Hospital Association, Texas Association of Health Plans, and Texas Public University Systems, i.e., University of Texas, Texas A&M, and Texas Tech.

9a. In the opinion of your agency, has the committee met its mission and made substantive progress in its mission and goals?

Yes

9b. Please describe the rationale for this opinion.

The committee has not met, but the process for creating the committee is on track. Additional information will be available in 2017 to better assess the progress of the committee.

10. Given that state agencies are allowed the ability to create advisory committees at will, either on an ad-hoc basis or through amending agency rule in Texas Administrative Code:

10a. Is there any functional benefit for having this committee codified in statute?

No

10b. Does the scope and language found in statute for this committee prevent your agency from responding to evolving needs related to this policy area?

No

10c. If "Yes" for Question 10b, please describe the rationale for this opinion.

N/A

11a. Does your agency recommend this committee be retained, abolished or consolidated with another committee elsewhere (either at your agency or another in state government)?

Retain

11b. Please describe the rationale for this opinion.

Based on analysis recently conducted and recommendations approved by the HHSC Executive Commissioner on 10/31/15, this advisory committee should be retained

12a. Were this committee abolished, would this impede your agency's ability to fulfill its mission?

Yes

12b. If "Yes" for Question 12a, please describe the rationale for this opinion.

Elimination of the committee would impede the ability of the Medicaid/CHIP program to obtain comprehensive stakeholder feedback on value-based payment initiatives.

13. Please describe any other suggested modifications to the committee that would help the committee or agency better fulfill its mission.

None.